

**DHHS Office of Adult Mental Health Services QUARTERLY REPORT -- ¶280
May 2006**

INTRODUCTION

This is the first of the reports of the Department of Health and Human Services under the June 30, 2005 Consent Decree plan. By this report, the Department will:

- Report on implementation of specific action steps in the Consent Decree Plan designed to complete development of a comprehensive community mental health system;
- Present data that shows how the system is operating relative to the performance standards; and
- Report corrective actions that DHHS is taking in response to monitoring data on performance standards.

Part I of the quarterly report addresses implementation of the specific action steps in the Consent Decree Plan designed to complete development of the system. Progress on the action steps relating to system development at Riverview Psychiatric Center have been included as part of the reporting on Riverview performance measures in Part II.

Part II includes monitoring data showing how the system is operating in reference to the performance standards in the approved Plan. The first section contains data relating to the community standards and the second section contains performance measures data for the Riverview Psychiatric Center along with the progress on action steps. Future reports will describe any action, for each set of standards, the Department is undertaking (or plans to undertake) to address areas where data shows the system is performing below those standards.

Part III includes updates on the cost of plan implementation and any other issues that warrant reporting to the Court Master.

Part IV is the Riverview Psychiatric Center Performance Improvement Report for the third quarter of FY 2006.

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I. System Development

A. Managed Care

In July of 2005, the Department held meetings with consumers and providers about behavioral health managed care. At those meetings, the Department introduced some basic concepts regarding managed care implementation and provided opportunities for the community to “think out loud” about their concerns for a new behavioral health care system. The Department also agreed at the meetings to involve stakeholders throughout the designing and implementation of managed care.

In December of 2005, the Department published a Concept Paper outlining its vision for the managed behavioral health care system in Maine. That concept paper is Attachment 1.

To assure ongoing stakeholder involvement, the Department has created a Managed Care Stakeholder Group. The Stakeholder Group is made up of representatives from consumer and family groups, provider associations and advocacy groups. In addition to the Department groups, a consumer public policy forum, sponsored by AIN and GEAR Parent Network, was held on February 25, 2006. See Attachment 2 for a report, “We the People: Managing Our Behavioral Health Care.”

The Stakeholder Group has formed four subgroups to provide greater opportunities for consumer, family and provider input. The subgroups cover the following areas: children, adults with SPMI, elders and adults, and substance abuse. Each subgroup was asked to focus on what is working in the system and should remain in a managed care system, what isn’t working, and what should be priorities for addressing problem areas. The Managed Care Stakeholder Group will review reports of the subgroups in May (see Attachment 3). Stakeholders will then make recommendations to the Department in the areas such as service coverage priorities, performance measures and standards, access standards, and complaints and grievances.

AMHS, in response to stakeholder input, has formed a housing subgroup to examine issues across population groups.

The Department will also hold public forums around the State. Information from the Stakeholder Group and subgroups will inform decisions about components of the managed care benefit, such as coverage priorities, performance measures, and access standards that the Department can share at these forums.

The Department has created a website to facilitate the dissemination and sharing of information about the work of the Stakeholder Group and its subgroups. Rough notes of all the meetings are on this site, as are various managed care resources and public comments. This site is located at:
<http://www.GoodGroupDecisions.com/ManagedCare>

Stakeholder input thus far has already resulted in changes to the Department's plan for implementing managed care. An initial step will now include providers undertaking readiness assessments.

A significant aspect of these assessments will be "service reviews." These will provide the Department with information about gaps in continuity of care, while giving providers information about areas requiring attention and change within their own organizations.

The service reviews will be performed on the following services:

- Community Support Services
- Hospital Services (mental health and substance abuse only)
- Psychiatric Facility Services (provided by private psychiatric facilities in Maine and out of state)
- PNMI (behavioral health only; Appendix B, D and E facilities only)
- Outpatient services for persons who are also receiving community support and/or PNMI services, up to a maximum of 10,000 members.

These reviews will be phased in starting in July, 2006, with all services being reviewed by December 31, 2006. The Department is expanding its contract with Beacon Health Strategies to facilitate the assessments and to assist any service delivery changes that may become necessary.

The Department is currently developing an RFP for risk-based managed care with an anticipated start date of January, 2007. The contract resulting from this RFP process would provide for the management of all the above behavioral health services, including contracting with providers, negotiating rates with providers, quality assurance and improvement, and utilization management. The Department will continue to seek stakeholder input through the Managed Care Stakeholder Group and its subgroups in regard to the performance measures to be included in the RFP and the resulting contract.

The Quality Management Plan for the managed care entity has three major components: ongoing review of contract performance standards, projects which will include reviews to assure compliance with the Consent Decree, and an external evaluation.

The federal regulations governing managed care programs require that States contract for an annual external quality review of each managed care plan. The External Quality Review Organization (EQRO) will analyze and evaluate aggregated information on the quality, timeliness and access to the health care services furnished to Medicaid recipients. The mandatory activities for EQROs are:

1. Validation of performance improvement projects required by the State to comply with federal regulations that were underway during the preceding 12 months;
2. Validation of the managed care entity's performance measurement data reported (as required by the State) or the performance measures calculated by the State during the preceding 12 months;

3. A review, conducted within the previous 3-year period, to determine the managed care entity's compliance with standards established by the State to comply with quality improvement projects outlined in the State's quality plan/strategy.

The State may choose to contract for optional EQRO services that use information derived during the preceding 12 months:

1. Validation of encounter data reported by the managed care entity;
2. Administration or validation of consumer or provider surveys of quality of care;
3. Calculation of performance measures in addition to those reported by the managed care entity and validated by the EQRO as required above;
4. The conduct of performance improvement projects in addition to those conducted by the managed care entity and validated by the EQRO;
5. Conduct of studies on quality that focus on a particular aspect of clinical or non clinical services at a point in time;
6. Technical assistance/guidance to the managed care entity to assist them in conducting activities related to the mandatory and optional activities that provide information for the external quality review.

DHHS will be issuing an RFP for the external evaluator during calendar year 2007 as the external evaluation requires a year of data to perform the review.

B. Action Steps to Improve Consumer Involvement

Action Step 1: Transition to Consumer Council System

DHHS worked with the Consumer Advisory Group and other consumer stakeholders to identify and clarify the appropriate participants for a planning workgroup for the development of the consumer council system. The workgroup consists of consumer representatives from several key organizations. The group is charged with developing a structure for broader consumer input to the process. The workgroup has re-named itself the Transitional Planning Group. This group initially met on March 8, and agreed at that time to utilize facilitation services for the process. The group has met twice with the facilitator, once on April 5 and once on April 19, 2006. An approved summary of the April 5th meeting, labeled Transitional Planning Group 4/19/06, is Attachment 4. When substantive information is available from this group, the Transitional Planning Group will share it with the broader consumer community for feedback.

The Transitional Planning Group has joined with the Consumer Advisory Group to function in an advisory capacity to Adult Mental Health Services. This interim advisory group sets its own agendas and provides valuable consumer voice to AMHS as well as helps identify additional avenues for consumer voice. The combined group continues to meet on a monthly basis. This group has worked to plan a special consumer forum on May 4, 2006 to provide an opportunity for the larger consumer community to meet with Elizabeth Jones and discuss issues of continuity of care and vocational services. A flier for that meeting, labeled Consumer Advisory Group Forum, is Attachment 5.

Additionally, consumers are included in various stakeholder workgroups, such as the Managed Care Stakeholder workgroups described in Section A and are valuable participants in training opportunities.

A supplemental budget request was made to the Governor's Office to fund the Consumer Council System and the second session of the 122nd Legislature approved \$323,000.

Action Step 2: Clarify Basic Elements of Consumer Council System

Work is underway with the Transitional Planning Group to clarify the basic elements and structure of the Consumer Council System. As substantive proposals are developed, they will be widely circulated, with identified feedback loops, to the broader consumer community using electronic media and Web postings.

Action Step 3: Provide Ongoing Support to Councils

AMHS presents issues to the Consumer Advisory Group (CAG) in as timely a manner as possible. Suggestions from the CAG to improve this process continue to be incorporated into practice. Refer to Section F: Assuring Quality Services for additional information. Monthly and quarterly reports will be made available to the Consumer Council System for review and feedback on quality assurance and quality improvement.

Action Step 4: Assure Adequacy on Maine Warm Line

The Amistad state-wide warm line has been in place since November of 2005. It is well utilized by consumers throughout the state. Additionally, efforts have been made to coordinate with various local warm lines across the state. Anecdotal reports indicate that calls have increased to local warm lines since the inception of the Maine Warm Line. The Department will continue to evaluate usage and programming to ensure that the needs of Maine's consumers are met.

Amistad has made visits to local warm lines at CHCS, Mid-Coast, Sweetser, and Hope Recovery Center to discuss warm lines operation and ideas for collaboration. Maine Warm Line's phone message lists the Hope Center and CHCS warm lines as alternative resources.

Action Step 5: Improve Peer Services in Emergency Departments (EDs)

Peer Support services were being provided in the Maine Medical Center emergency department by Amistad through a previous contract. Following an RFP process, DHHS entered into contracts with both Sweetser and Amistad to provide trained peer support in a total of three emergency departments. The term for the first contract period for both entities is 1/1/2006 to 6/30/2006. Amistad provides peer support at the Maine Medical Center Emergency Department from 5:00 p.m. to 11 p.m. daily. Sweetser's Learning and Recovery Center has begun to provide peer support in two Brunswick area emergency departments, Midcoast Hospital and Parkview Hospital. This program operates from 3:00 p.m. to 11:00 p.m. Monday through Friday and 7:00 a.m. to 11:00 p.m. on Saturdays, Sundays and Holidays.

The same monthly reporting form (Attachment 6) will be used by both programs. Outcomes from the programs will be evaluated to inform Department decisions about the viability of any future expansion of peer support services provided in emergency departments.

Action Step 6: Promote Consumer Participation in Licensing

Consumer participation in licensing will first be addressed by the Transitional Planning Group. AMHS will then take additional steps to provide outreach, training and financial support to consumers to ensure adequate participation in licensing reviews. This cost is combined with the cost of the Consumer Council System.

Additionally, in this session the legislature approved \$100,000 for the Advocacy Initiative Network (AIN) for leadership training and consumer development. AMHS will be working with AIN to develop the contract for this.

C. Enrollment, Service Review, and Individualized Support Planning

•Enrollment

The Office of Adult Mental Health Services began the enrollment process (Attachment 7) for Community Support and PNMI Services in July 2004 and had enrolled all current consumers by October 2004. This was a labor intensive system with enrollment forms in a paper format. AMHS worked with stakeholders to revise the form both for better data gathering and for electronic submission, and the version 2 enrollment form (Attachment 8) was completed in July 2005. AMHS implemented eNET-ME, a web-based and HIPAA compliant secure data base, and, by January 9, 2006, all providers were required to submit enrollment forms electronically.

The switch to electronic submission from providers required both training and provider changes to existing data collection. A web-based process whereby providers could enter individual enrollments electronically, without specialized hardware or software, and a batch system has been tested and implemented.

AMHS and the providers have completed a successful transition to an electronic system and DHHS is now able to produce reports on who is in service and who has left service, and for a variety of other demographics. See Attachment 9a, 9b, and 9c for sample reports.

• Service Review

Service Review began in February 2005 for the purpose of:

- Assisting agencies in determining whether the level and intensity of services is appropriately matched to the consumer's level of need;
- Assessing whether the services are successfully helping consumers meet their Individualized Support Plan (ISP) goals;
- Improving consistency in delivering Community Support and PNMI Services;
- Identifying quality improvement opportunities.

The Clinical Advisors, under a contract with Beacon, perform all interviews telephonically and record information in an electronic file format for ease of report production.

In the first phase of the Service Review process, all consumers who had a year or more in Community Support Services and who were receiving MaineCare, were selected as the universe to be sampled, for a total of 4,757. Each provider agency received a service review of 20% of the consumers who fit this universe.

Consumers were divided among the three DHHS service regions as follows:

- Region I-----314 total reviews including 76 class members
- Region II-----472 total reviews including 160 class members
- Region III----261 total reviews including 20 class members

The Clinical Advisors conducted 1047 Service Reviews (see Attachment 10 for the protocol) between February 2005 and June 2005.

As Phase two of the Service Review process, the Clinical Advisors conducted follow up reviews, on 22% or 231 cases, selected based on the following criteria:

- The consumer was in crisis at the time of the initial Service Review
- The consumer had substance abuse and/or medication management issues that were impeding progress in treatment;
- The consumer was transitioning to a higher or lower level of care at the time of the initial review and follow-up was indicated to see the outcome of the transition;
- The ISP goals did not seem to address the clinical issues and/or needs of the consumer at the time of the initial service review;
- The consumer did not appear to meet criteria for the current level of care at the time of the initial service review.

The follow up reviews began on October 1, 2005 and were completed by October 31, 2005.

AMHS developed a second version of the Service Review protocol (Attachment 11) for the third phase, a review of ACT and ICI services. The protocol was completed in December 2005 and the reviews began in February 2006. A total of 1196 people receive these services and DHHS is sampling 40% for a total of 479.

A fourth phase is currently in development to review PNMI services. The protocol has been developed and DHHS is currently developing a sampling methodology. See Attachment 12 for the PNMI protocol and Attachment 13 for sample Service Review reports.

• Individualized Support Plans

The electronic system for capturing timeliness of ISPs and unmet needs by agency, by region, and by individual was launched on March 1, 2006. This system covers all class and non-class members who are receiving Community Support Services, PNMI Services, or ICM services, or who are class members who contact a Consent Decree Coordinator with a resource need that is not readily met. Providers were trained both at regional forums as well on site at agencies. Attachment 14 is the manual for the ISP Resource Data Summary (ISP RDS). Reports will be generated beginning in June, when there will be sufficient data in the system to make the reports meaningful. This data will then be incorporated into the Performance Standards, where applicable. See Attachment 15a 15b, and 15c for sample report templates.

D. Action Steps to Improve Vocational Opportunities

- **Background**

The Department has contracted with Elizabeth Jones to address the vocational action steps outlined in the Department's November 18, 2005 submission to the court master. Ms. Jones brought in Ms. Roberta Hurley, a vocational consultant with previous experience in Maine to assist her on vocational issues related to compliance. The original deadline for the vocational services report was to be May 1, 2006. This deadline has been extended to May 31, 2006 to enable completion of all the necessary work.

Ms. Jones and Ms. Hurley met with a small group of consumers at Amistad in Portland in February 2006 to hear their concerns about vocational opportunities. In March and April 2006, Ms. Jones hosted a large meeting of stakeholders in Augusta to hear their response to the DHHS November proposal. DHHS staff participated in all three meetings. The minutes of the March stakeholder meeting are Attachment 16.

- **Update**

Below are updates for each of the Action Steps identified in the November 18, 2005 submission.

Action Step 1: Expand Employment Expertise in Provider Agencies

Recently DHHS staff participated in a consultation with John Halliday of the Institute for Community Inclusion at the University of Massachusetts in Boston. Mr. Halliday is a national expert in the area of employment for persons with disabilities including state vocational rehabilitation services. His clear message to DHHS staff was that occasional training opportunities for case management staff would likely not result in a greater emphasis on employment with clients receiving case management services. Mr. Halliday suggested that DHHS consider phasing in:

- 1) A requirement that the certification (Mental Health Rehabilitation Technician or MHRT/C) required for case managers include an employment component, or
- 2) A requirement that case management agencies include similar information in their orientation for new employees.

He recommended that either requirement be coupled with at least yearly training opportunities in vocational areas that reinforce and expand on the initial training or orientation requirement.

Pursuant to this discussion, DHHS staff is exploring whether and how to modify the existing Maine Employment Curriculum (MEC) to include it as part of the MHRT/C curriculum, or as part of new employee orientation for community support workers. The MEC was developed via a yearlong collaboration between the University of Maine's Center for Community

Inclusion and Disability Studies, the former Maine Department of Behavioral and Developmental Services and the Bureau of Rehabilitation Services. It is a comprehensive curriculum on best practice employment supports for individuals with disabilities. Ms. Hurley has examined this curriculum and found it to be comparable to the more widely known curricula from the University of Hartford and Virginia Commonwealth University.

DHHS staff has met with staff of the Center for Community Inclusion to discuss how to adapt the MEC for this purpose, and how this training would best be delivered to its target audience. Ms. Jones' report will most likely have recommendations in this area, including the timing, method and frequency of delivery of this training. DHHS will use these recommendations to modify and then implement our plan to provide training related to employment for community support workers.

Action Step 2: Expand Employment Support Alternatives

DHHS staff has participated in two meetings with Elizabeth Jones and numerous stakeholders, including providers and consumers, to discuss the best way to enhance employment support alternatives. DHHS also obtained additional funding (\$200,000) for vocational services in the recently passed supplemental budget. DHHS staff is reviewing different models of employment support offered to adult mental health consumers in Maine to assess the relative strengths of these models.

DHHS has delayed its development of an RFP as described in the November 18, 2005 submission in order to incorporate in that RFP Ms. Jones' recommendations in this area.

Action Step 3: Improve Long Term Vocational Support Program

DHHS Central Office staff continues to meet with the three Regional Long Term Vocational Support Coordinators and the Rehabilitation Counselor from Riverview Psychiatric Center to discuss program improvement and maintenance issues. A major focus area is the extent and quality of local coordination between the Vocational Rehabilitation and Long Term Vocational Support programs. The Long Term Vocational Support Coordinators were also involved in the analysis of the proposed DVR Order of Selection Screening discussed in #4 below.

Ms. Jones' earlier recommendations to the Court identified a specific fidelity instrument strongly tied to a specific model of employment support – the Dartmouth-Hitchcock Individual Placement and Support Model of Supported Employment. Members of the stakeholder group have expressed concerns about an exclusive commitment to a specific model of employment support and have urged consideration of an outcome measure instrument vs. a fidelity instrument. DHHS is looking forward to reviewing Ms. Jones' recommendations on this issue to help resolve this matter.

Action Step 4: Improve Services by Monitoring the VR Wait List

DHHS staff has regularly tracked the status of the DVR wait list through bi-monthly meetings with staff from both agencies. The wait list time has been reduced from 12 to six months, though this varies depending on the location of the DVR office. DVR anticipates that the wait list time will drop to three months by September 2006.

In response to feedback, including feedback received from DHHS, DVR withdrew its plan to implement the Order of Selection Screening Instrument. The Instrument would have changed the method now used by DVR counselors to determine a client's priority for services. From the DHHS perspective, the proposed Instrument would likely have resulted in adult mental health consumers having less access to DVR services than they currently have, and this concern was directly shared with DVR staff. DHHS expects to participate in a future discussion with DVR staff about an alternative plan.

E. Continuity of Care

AMHS is adding staff resources that will improve continuity of care. Chris Zukas-Lessard has been hired to fill the continuity of care manager position vacated by Diana Scully. Marya Faust has returned to the Quality Care Manager position and is developing a Quality Care Team. Additionally, Steve Sherritts has been hired for the Community Corrections Manager position and he will be starting mid-May.

Mr. Sherritts will be continuing the work begun as a result of the Department of Corrections and DHHS Joint Action Plan. The Steering Committee has begun meeting and workgroups on diversion and re-entry are in development of each of the 16 counties.

The Managed Care Organization (MCO) structure will include continuity of care components. The MCO will be responsible for ensuring that people are screened for the appropriate level of care and gain access to needed services. Therefore, many of the components included in the Crisis Services' Action Plan will be discussed with managed care stakeholder groups as the Department requests input for the overall design of the managed care system.

While much work continues, Maine was ranked by NAMI as one of the top five states in the nation for its health care system for people with serious mental illness. Connecticut and Ohio were the top ranked states each receiving a "B" and Maine, South Carolina, and Wisconsin each received a "B-".

Crisis Services

Consistent with the court master's December 9, 2005 Order, the Department is proceeding with the Action Steps for Improving Services and Continuity of Care for Persons Experiencing Psychiatric Crises, submitted on November 18, 2005. As the report below demonstrates, DHHS has made some progress in this area. Efforts have been hampered, however, by a three month vacancy in Continuity of Care Manager position. As noted above, that position has now been filled.

Also, it has become clear that assessment and implementation of these action steps is contingent on the work that the Department's consultant, Elizabeth Jones, has undertaken. Ms. Jones is currently:

- Examining crisis services based on the Court Master's December Order and the Department's *Action Steps for Improving Services and Continuity of Care for Persons Experiencing Psychiatric Crises* submitted as part of the fulfillment of consent decree requirements;
- Focusing on the Action Plan and crisis systems including services the Department contracts with agencies to provide;
- Looking at the use of and possible expansion of observation beds;
- Examining the use of beds at Riverview Psychiatric Center;
- Examining the use of Emergency Departments as part of the crisis system.

See Attachments:

CLASS Minutes of February and March 2006 (17 a and b)
Hospital Initiative Minutes of February and March (18 a and b)
DHHS/Elizabeth Jones contract (19)
Elizabeth Jones Tasks and Timeframes (20)
Elizabeth Jones Work Group and Meeting Times – several meetings have been arranged in addition to the original work plan. (21)
Elizabeth Jones February report of February 2 – March 3, 2006 (22)
Elizabeth Jones March report (23)

Her recommendations are necessary for the Department to finalize decisions regarding crisis services improvements. The Department will reflect these recommendations, which are due to the Commissioner in July 2006, in future reporting on the crisis service action steps.

1. Appropriately Direct Statewide Crisis Number Phone Calls

AMHS is now collecting misdirected call information and is developing a procedure, together with Children's Services, to make the necessary corrections to redirect the exchanges. It is too early to determine if public information campaigns or other strategies are needed as the procedures for redirecting may be sufficient. See Attachment 17 a and b - CLASS Minutes of February 3, 2006 and March 29, 2006.

2. Increase use of Crisis Stabilization Units

Work described in this action step is being addressed by Ms. Jones.

3. Finalize Standards for Crisis Services

The CLASS sub-committee finished their work on the crisis standards and has submitted them to DHHS for their review. Once the Department has made final decisions for the use of crisis beds, observation beds, and connections to the community, the Department will review the standards for consistency with those decisions, seeking necessary input from the CLASS sub-committee and the Consumer Advisory Group, before adopting final standards.

4. Increase Access to Psychiatric/Psychological Services

AMHS worked with the Office of MaineCare Services to provide a clarification to current MaineCare rules to allow psychiatric nurse practitioners to be included with psychiatrists to deliver certain services. The MaineCare rules were not current with accepted practice and scope of license, so this change has helped providers expand their services.

Tri-County Mental Health Services has increased the use of Nurse Practitioners to assess clients for medical clearance when considering hospitalization. The NP is able to see clients in their homes as appropriate, allowing clients to remain in their home rather than wait for service in an emergency department. In addition to reducing the time to receive service, this arrangement is much less traumatic for the client.

Common Ties in Lewiston has added an ICI Team and medication management services utilizing a nurse practitioner.

Community Correctional Alternatives has added medication management, utilizing a part time psychiatrist and Employment Specialists of Maine has added a psychiatric consultant to their PNMI program. The 19 clients served in the PNMIS will now have direct access to psychiatric consultation.

The Department is assessing whether, in light of these actions, it is necessary to make further changes to provider contracts or to require use of telemedicine.

5. Use of Peer Support in Emergency Departments

DHHS has developed outcome measures for peer support services in EDs. Amistad and Sweetser will report on these for the peer services they are now providing in Emergency Departments pursuant to contracts with DHHS. See Attachment 6.

6. Implementation of Rapid Response Process

See Attachments 24 a and 24 b for the draft of the AMHS Rapid Response Protocol. This process is being reviewed by the CLASS and Hospital Initiative Group and the Consumer Advisory Group in May and June. Implementation is targeted for July 1, 2006.

The Maine Hospital Association Mental Health Council (MHC) is collecting data on people with a behavioral health diagnosis in the Emergency Department regarding length of stay, transfer, discharge, and admission to the two state hospitals. This information is reviewed at MHC meetings on a monthly basis by community hospitals, the two state hospitals, the psychiatric inpatient hospitals, and AMHS to help solve system issues.

7. Assure Clinical Capacity in Emergency Departments

When clinical capacity in the Emergency Department is insufficient and resolution of the client service needs has not been accomplished, the Rapid Response Team will be called upon (see Action Step 6). Clinical capacity in all services components will be a requirement in the Managed Care RFP. The Department will evaluate whether a rule change to assure clinical capacity remains necessary with implementation of managed care.

8. Assure Appropriate Use of Blue Papers

DHHS AMHS and the Attorney General's Office have developed and will present a training session on involuntary commitment on June 13, 2006. Presenters in this all day session will include a member of the Judiciary, defense attorneys, physicians, psychologists and a consumer. The program is targeted to mental health professionals, ER physicians, lawyers and judges. The training will also address changes necessary to implement amendments to the blue paper process adopted during the current legislative session. See Attachment 25 for the training agenda.

Elizabeth Jones will meet with Riverview Psychiatric Center, Dorothea Dix Psychiatric Center, Spring Harbor Hospital, and Acadia Hospital to examine their roles, access, and connection to the community. Ms. Jones will also meet with the community hospitals and the four IMDs to examine the

interrelationship of their roles and the community providers. Discussions about blue papers will be part of these meetings.

Any changes to the Guiding Principles will reflect the outcomes of these meetings as well as Ms. Jones' recommendations.

9. Support Use of Observation Beds

The use of Observation Beds is part of the contractual work with Elizabeth Jones. Her recommendations regarding the expanded use of observation beds will be considered by the Department in July of 2006.

10. Improve Transition/Discharge Planning

The Community Support agencies have received a letter from the Acting Director of Adult Mental Health Services to address the issue of case management assignment and discharge planning at state and community hospitals. See Attachment 26, Letter of April 19, 2006.

The Acting Director of Adult Mental Health, the Region I and II Team Leaders and Utilization Review Nurses, and Superintendent and Deputy Superintendent of Riverview Psychiatric Center (RPC) have instituted a joint discharge planning meeting. It was determined that the large number of clients discussed at the weekly meeting and the multi-region focus was not productive. A decision was made in January, 2006, to move to a format that would focus on fewer patients and one region per week. This format allows for a more thorough discussion of the often multiple challenges to discharge for some individuals. During the weekly discharge meeting, provider agencies are expected to be available by phone to be part of the process.

To improve the state hospital discharge planning process and to obtain a more accurate picture of development needs, the Office of Adult Mental Health Services and staff from RPC met on March 19, 2006, to assess patient needs. Court Master Wathen, Sharon Sprague, Dr. Daskivitch, and Sheldon Wheeler developed a tool (Barriers/Planning Document) to identify planning and new development needs. The aggregate data is informing the Department regarding the appropriate use of the Supplemental Budget funds. See Attachment 27 Barriers/Planning Document.

Additionally, Ms. Jones has made a preliminary review of bed capacity at Riverview Psychiatric Center. See Attachment 28 for this review. This document will be considered with Ms. Jones' final report before actions are implemented.

The Department has not yet proposed a rule to require hospitals to obtain ISPs.

11. Promote Stronger Synapses

On April 24, 2006 the Department presented a workshop titled, "A New Understanding of Distress & Suicidal Behaviors – Changing Our Approach Together: A Maine Systems' Challenge". The keynote speaker was Dr. Kirk Strosahl. Psychiatric center staff, emergency department staff, crisis clinicians, consumers, police, sheriffs, community providers, and state staff

discussed how they can better serve people in need of intervention and treatment.

The conference objectives were:

- To explore unified strategies for collaboration between providers and consumers;
- To learn ways to respond more effectively to individuals in the community who participate in multiple systems of care;
- To explore a different model for understanding risk management;
- To increase provider motivation for person-centered care;
- To provide alternatives to the “revolving door” at psychiatric centers;
- To provide hope and make a difference in the community.

The afternoon session focused on small group discussions intended to improve collaboration and coordination within each region. Conversations focused on how Maine providers and consumers can take steps toward transforming traditional approaches to distress and suicidal behavior into a more effective service system.

The conference is evidence that the Department recognizes that there are individuals who are struggling to achieve recovery within the current adult mental health system of care. Often they cycle in and out of psychiatric facilities with little apparent benefit. Clearly, there are both clinical and systems issues present that are interfering with the ability to provide or receive effective treatment.

This workshop represents the Departments commitment to introducing emerging practices for thinking differently about distress and suicidal behaviors. The conference provided new tools for providers and consumers and the forum allowed local teams to come together to determine how this practice could be practiced within their own networks.

There are follow up meetings planned in each region to further discussions and implementation of the guidelines determined to be valuable by participants. The Department is deferring development of MOAs to strengthen the synapses in the mental health system until these discussions are complete.

The Department has not yet proposed rules making MaineCare payment for private practitioners contingent on their involvement in improving continuity of care. In the meantime, in addition to promoting coordinated treatment approaches, AMHS will also be working with the CLASS and Hospital Initiative Group to address the low usage of ISPs. Mental Health Team Leaders and the Acting Mental Health Director will be leading this discussion at the May meeting.

12. Promote Non-Traumatic Transportation

Non-traumatic transportation will be addressed by the Department of Corrections and DHHS Diversion and Re-entry Steering Committee. Input from this group will be sought at the June 2006 meeting. The recommendations from the Steering Committee will be carried forward to the diversion meetings currently in the development phase in all 16

counties. Additionally, this topic will be addressed by the Consumer Advisory Group.

13. Build Peer Services

See section I. B. for discussion of the implementation of peer services.

14. Clarify Release of Information

The Department did not propose a statutory change in this Legislative session.

The CLASS and Hospital Initiative Group will begin developing protocols to solve real or perceived confidentiality issues at the May meeting, with the expectation that the work will continue during the summer.

15. Promote greater Use of Advance Directives and Wellness Recovery Planning

Planning for training on advance directives and methods to measure system changes will begin in the fall of 2006.

16. Crisis Services Curriculum

The Department has not yet implemented the crisis services curriculum. The CLASS Crisis Curriculum Committee is drafting a response to an April 22nd curriculum review prepared by the Muskie School. The Committee is currently making revisions to include relevant MHRT/C training that is not in the proposed curriculum. See Attachment 17 b CLASS March 2006 Minutes.

17. Provide Training to ED Physicians and Nurses

Once the system expectations are clarified, a training plan will be implemented.

18. Enter into Clear, Rigorous Contracts

AMHS decided not to make changes to contracts beyond the existing FY 2006 language. Given the numerous changes expected as a result of managed care implementation and the yet-to-be-received recommendations from Ms. Jones, AMHS decided not to put providers through multiple contract amendments.

19. Propose Rules Relating to Community Hospitals

The Department has not yet proposed rules requiring hospitals to enter into MOAs. Nonetheless, AMHS expects that MOAs will be signed with hospitals after the modifications to the Rapid Response process are finalized. The connections between crisis providers, community services, and hospitals will become more formal under the managed care system. The Department will evaluate further the necessity for a rule after managed care is implemented.

20. Propose Rule Relating to Private Practitioners

Private practitioners who choose to be part of the managed care system and all practitioners who receive MaineCare payments or state general funds will be required to adhere to Consent Decree requirements as part of their contract with the managed care provider. See report on Action Step 11.

21. Set Rates

The Legislature in this session enacted P.L. 2005, ch. 519, Part ZZZ which stated, "Prior to implementation of administration or management of services, savings projected to be achieved by the managed behavioral health care services system may not be achieved through reductions in provider rates below their levels on January 1, 2006 or through elimination of categories of services provided by community providers or consumer groups."

DHHS has entered into a contract with Mercer Health and Benefits, LLC (see Attachment 29) to provide actuarial and data analysis services to assist in rate setting for managed care.

The expenditure data provided to Mercer will allow them to complete the Cost Neutrality section of the 1915 (b) waiver for managed care for submission to the Center for Medicaid and Medicare Services. It will also provide Mercer with the data needed to set the capitation rates that will be paid to the managed care vendor.

DHHS will have the cost neutrality section of the waiver completed in July 2006. The data book is slated to be available in August for review by potential bidders. Thus, this work sets the context for any change to crisis rates.

22. Implement Prior Authorization

Full prior authorization will be implemented upon the launching of managed care in January 2007. Beginning in July 2006, AMHS will begin to transition the current prior authorization practices for PNMI and limited MaineCare Section 17 services to Beacon.

F. Assuring Quality Services

AMHS is beginning to implement a Quality Care Management Plan organized into three main components:

Component One: Regional Ongoing Quality Assurance

- Record reviews
- Licensing
- Involuntary commitment reviews
- Contact with consumers in homes with 8 or more consumers
- Quarterly service letters to consent decree clients
- Termination of service reviews
- Services to people who are public wards
- Contract Review

The Consent Decree Coordinator in each region will assure implementation in each of these areas where appropriate and coordinates data collection and review. The CDC, for example, stays in contact with the Licensing unit to assure that all licensing reviews are up to date for the agencies in that region, to collect information on any corrective actions required, and to note any other issues raised in the licensing site visits. The CDC is the hub for gathering information about how well processes are working at the regional level. The CDC creates a monthly report for review at the monthly regional AMHS Team meeting, the monthly regional provider meeting, and will do so for the regional consumer councils once those are activated. These groups will review the report and do problem solving at the local level. System concerns and recommendations will be sent to the AMHS Quality Management Team for discussion at the AMHS Statewide Team meeting. The CDC will work with the Purchased Services' contract administrator to assure contract performance is part of the on-going regional review.

The CDC will be responsible for producing a quarterly report that tracks the regular reviews, notes any issues raised at the local level and corrective actions taken, and notes issues referred to the AMHS management for system-wide solutions, and actions that were taken.

The reports will be given on a quarterly basis to the Consumer Advisory Group, the Statewide and the Regional Consumer Councils once active, and to the Statewide Quality Improvement Council for review and recommendations.

Component Two: System Management

- Enrollment
- Prior Authorization
- Service Review
- ISP Resource Data Summary
- Grievances
- Critical Incidents

The Quality Management Team of AMHS will be responsible for assuring that these review and reporting processes are occurring, solving system design issues, and alerting appropriate stakeholders when issues are identified. It is the responsibility of this team to notify the region of any issues that may be resolved at

a local level. The Quality Manager will be responsible for completing a monthly report on system functioning and data generated for the AMHS Statewide Team, and the regional AMHS Team. System wide issues will be reported to the Statewide QIC and to the Statewide Consumer Advisory Council for their review and feedback. Additionally, a quarterly report will be produced to be shared with the QIC, the local and Statewide Consumer Advisory Council, and provider groups for review and problem solving. It should be noted, however, that Critical Incidents are reviewed on a daily basis and actions on those may be immediate.

Component Three: Performance Improvement Projects

Performance Improvement Projects are undertaken from time to time to give significant attention to areas identified as needing quality improvement. Each special project has a group assigned to work on it that includes consumers, Department staff, and providers. Each project team measures its progress, devises solutions to problems identified, and produces reports to document and further the work of the project. The following projects currently underway:

Improving Discharge at Riverview Psychiatric Center: This project includes a weekly review of the status of all discharges, identifying unmet needs for resources, policy clarification, and ongoing training.

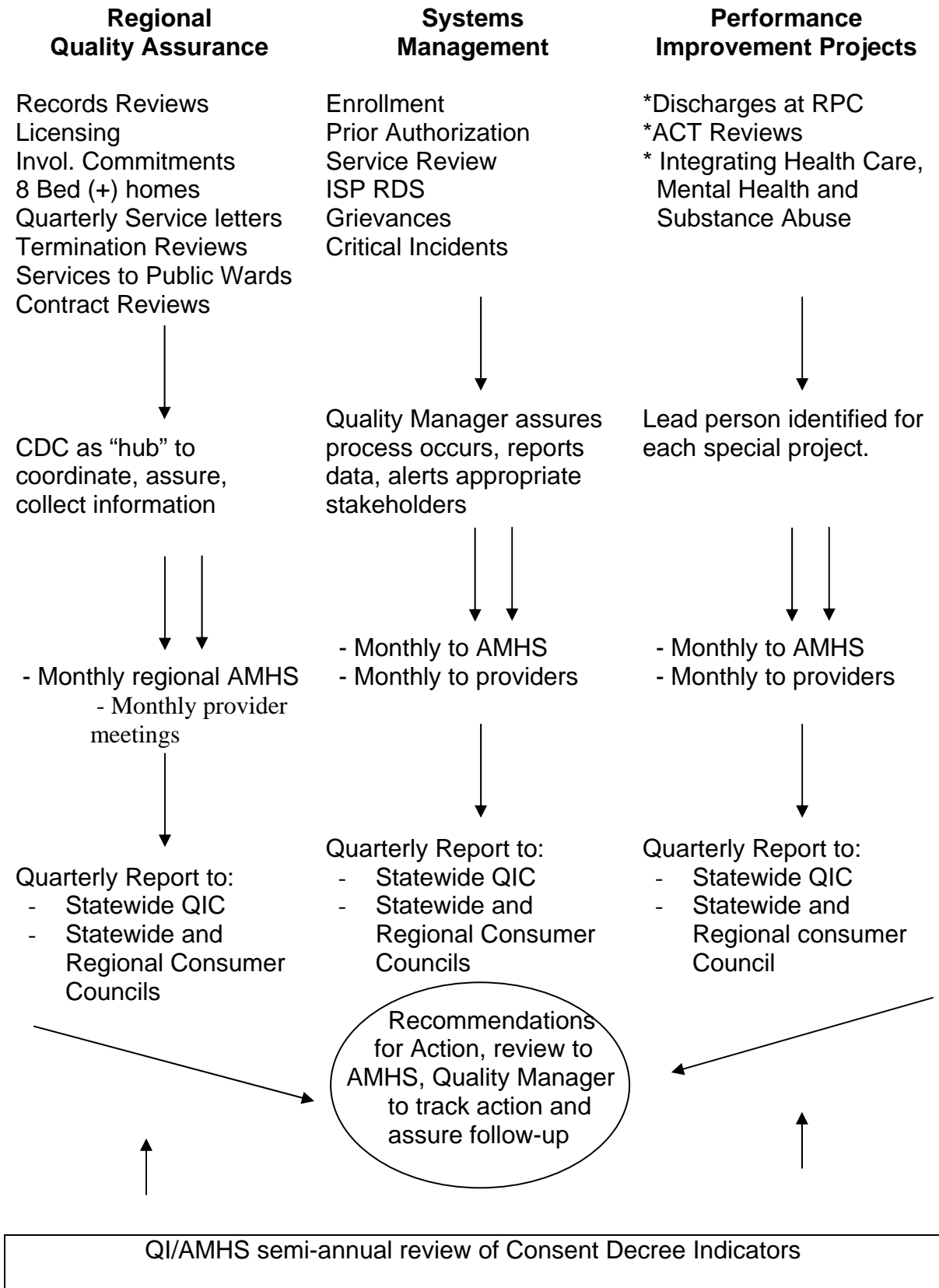
ACT Fidelity Reviews: Each agency ACT team will be reviewed by a team of consumers and departmental staff according to the evidence based practice fidelity standards. Agencies will receive feedback and assistance in improving practice.

Integrating Health Care, Mental Health, and Substance Abuse Services: There are two major initiatives for improving the integration of these services: the Co-Occurring System Infrastructure Grant and the Women's Behavioral Health Grant. Both are federal grants to improve integrating service at the local level by improving agency skills as well as removing system barriers. Additionally, DHHS is analyzing MECMS and Service Review data to assess the medical needs of consumers.

The monthly work of these groups will be summarized semi annually. This single report will be reviewed by departmental staff as well as the regional and statewide Consumer Advisory Councils and the Statewide QIC. Recommendations for performance improvement projects will be considered as will be action steps to improve performance issues.

Adult Mental Health Services

Quality Management Plan



II. Operation of the Mental Health System

A. Community Performance Data

Please insert, “Performance and Quality Improvement Standards, March 2006,” if you are viewing an electronic copy. This section details the standards negotiated as part of the Consent Decree and Attachment 30 presents the work plan for the missing data.

B. Riverview Psychiatric Center Performance Data and Progress on Action Steps

Chapter VIII of the Consent Decree Plan submitted on June 30, 2005 and subsequently approved by the Court Master with minor modifications includes a set of goals and objectives for improvements at Riverview Psychiatric Center, with action steps for each, followed by performance measures. This report summarizes the progress made to date on those action steps and also sets forth the performance data, or cross references to Riverview's quarterly Performance Improvement Report for the third quarter of FY 2006 (January to March, 2006, which is included as Part IV of this report.

Goal 1

Deliver hospital-based psychiatric care at Riverview Psychiatric Center that is consumer-centered, recovery-focused, innovative and appropriately integrated with community-based care.

Objective 1

To develop and implement a consumer-centered Inpatient Treatment Plan for Civil and Forensic clients within seven calendar days of admission that integrates hospital treatment with the attainment of community-based resources and supports necessary for the client to return to his/her community.

Active Progress:

- 1) As clients are assessed to be appropriate for admission to RPC, the admissions coordinator begins the process of gathering appropriate information to assist in assuring consumer-centered care. If the client has an ICM, a copy of the clients ISP is requested.
- 2) Upon admission to RPC, clients are assessed by a multidisciplinary team. The nurse, psychiatrist and medical doctor begin to complete discipline specific assessments to formulate an integrated service plan for each individual client. The assessments are designed to assist in capturing acute psychiatric, medical and dental care needs with resultant referrals, as well as to promote recovery.
- 3) Within three working days of admission, the CCMs and Treatment team coordinator assemble the client, identified clients community providers and natural supports to provide support to the client and information to assist the team in the development of a client centered ISP

Strategy 1

Develop, implement and train all direct care and clinical staff in a comprehensive treatment and discharge planning process that includes client participation and results in an integrated, competency-based plan consistent with the client's ISP (if any) and including:

Target completion date: 95% of current clinical staff will participate in Inpatient Treatment Plan training by 7/1/05.

95% of new hire clinical staff will participate in Inpatient Treatment Planning within 90 days of employment.

Active Progress:

- 1) As of 7/1/05, 75% of direct care staff had been trained in Comprehensive Service Planning.
- 2) Remedial training resulted in 90 % (of the remaining 25%) of tenured employees

having received training as of January 1, 2006. These remaining 4 staff have not been trained. Efforts to provide follow-up training of these four staff will be continued. Issues such as use of FML, and disability leave and other forms of sick leave have been identified as barriers.

- 3) Since 7/05, 100% of newly hired permanent clinical staff attends treatment planning training.

Strategy 2

A) Review and revise Forensic treatment plans by:

Active Progress:

- 1) Riverview staff has worked with all clients referred from the jail or prison system to participate in initial continuity of care meetings. It remains difficult to involve regular jail staff in this meeting, and the success rate has been low. At this time, the hospital is working with jails to identify a procedure to assure that communication begins at the initiation of treatment.
- 2) Riverview has assigned a correctional liaison for each jail and the state prison to develop a working relationship between the facilities and RPC.
- 3) Prior to a transfer to the jail or state prison there is communication between providers on care issues; the discharge plans and necessary instructions are communicated.
- 4) Rapid stabilization bed for 72 hour assessment of jail clients is now in operation.

B. Continuously assess appropriateness for petitioning the court for modification to conditions of clients found Not Criminally Responsible. As part of the treatment plan for each client who has been admitted as NCR, a safety plan is established identifying the behavioral criteria to trigger utilization of new conditions of modified release.

Active Progress:

- 1) The service plan review forms currently prompt a safety assessment identifying the behavioral criteria that would trigger utilization of new conditions.
- 2) Each treatment team meeting asks the question: Is the client at the maximum amount their level allows? If the answer is affirmative, it triggers a request for a new court order.
- 3) A report and petition are filed with the court within 10 days of Treatment Plan review if the review indicates current conditions restrict client care delivery. Quality Assurance data shows that this has occurred within the following time frames: 45% within 10 days; 67% within 14 days; and 100% within 25 days.
- 4) Institutional reports are filed annually for all clients committed to the care of the commissioner.
- 5) The number of court petitions is at a record high of 18 in April 2006 (at the last hearing).

Target completion date: By June 15, 2005 each NCR client's treatment plan review will:

- 1) Include a safety plan identifying the behavioral criteria to trigger utilization of new conditions, and
- 2) Document the assessment of adequacy of current court conditions as part of the review.

Current status: Completed.

Strategy 3

Expand and intensify treatment and education program options by:

- A.** Extending services in the evenings and weekends to include six hours of structured psycho-educational and rehabilitative services provided until 7:30 pm each evening of the week, in addition to services during the day.

Active Progress:

- 1) Since July 1, 2005, Rehab Aides provide recreational opportunities each evening of the weekday, as well as on weekends from 8-4:30.
- 2) Psychology staff is in-house on Saturdays.
- 3) Chaplain Services are available on Sundays.
- 4) Peer Support has been extended to be available on weekends.

- B.** Transforming Mental Health Worker positions into care delivery agents by implementing a “level of support” protocol for Mental Health Workers to facilitate providing rehabilitation in the area of improvement in primary functional capacity (e.g., personal hygiene, personal space maintenance, self care) and Self Expression Program for all clients assessed with such needs.

Active Progress:

1. MHWs have participated in a variety of trainings over the last 20 months to increase their level of support function, and to be able to assist clients in improving their functional capacity and self expression.
2. Each unit is developing a milieu manager position to enhance MHW service delivery.

- C.** Providing prescriptive small group activities on the units to address the needs of those unable to participate in the treatment mall;

Active Progress:

Unit Based groups occur on all four units. Groups are offered by disciplines including psychologists, Nursing, Therapeutic Recreation, Mental Health workers and Chaplain Services.

- D.** Developing an educational program to address the needs of the Incompetent to Stand Trial population.

Active Progress:

A forensic unit psychologist offers a structured educational program on this topic.

- E.** Providing an educational orientation to the circumstances, process and outcomes of NCR and Stage III clients;

Active Progress:

Dr. Leblanc has offered in-service training to all staff regarding the circumstances, process and outcomes of NCR and Stage III clients. The sessions were taped for forensic staff who were not able to attend the in-service. Tapes of the overview are available to staff who were unable to attend. 85% of forensic staff has been trained to date.

- F.** Increasing access to vocational rehabilitation services by adding two positions.

Active Progress:

One position has been added and a second position identified but not as of this date reclassified as it is currently filled by a person out on extended disability leave. Resolution of this situation is being sought through state personnel.

- G.** Defining rehabilitation actions in the treatment plan.

Active Progress:

This occurs for each client within seven days of admission as part of the revised comprehensive service plan process.

H. Conducting at least two care reviews per year through an existing contract with Dartmouth University to examine risk management practices and advise staff regarding performance standards appropriate to treatment and court-ordered procedures for forensic clients.

Active Progress:

Dr. William Torrey of Dartmouth has been to Riverview three times this fiscal year (October 13, December 12, and March 7) and has done case conferences on six clients. There have been 16 internal case conferences directed by the Medical Director and discussing challenging cases in the current fiscal year

I. Implementing a Riverview-facilitated process to connect client family members with the local NAMI Family-to-Family program and any family psycho-educational services available in the home community.

Active Progress:

- 1) Peer Support and CSS both ensure that clients and their families or natural supports are offered support in connecting with services in their communities.
- 2) NAMI link is provided on the Riverview Psychiatric Center web page.

J. Establishing a Riverview Psychiatric Center Web page with links to local supports.

Active Progress:

This has been accomplished since 10/05.

<http://www.maine.gov/dhhs/riverview/index.shtml>

K. Implementing a Riverview-facilitated process to connect clients with local peer supports providing services in or near their home communities.

Active Progress:

- 1) RPC web page provides such a connection;
- 2) Peer support workers provide information and assist clients in connecting with the peer support groups in their communities.

L. Establishing peer support groups at RPC.

Active Progress:

Peer Support has been offering groups on the treatment mall since 6/20/04.

M. Utilizing Peer Specialists and rehabilitation staff to conduct a minimum of one client outing per month to peer social and support groups.

Active Progress:

AMISTAD outings occur weekly.

Target completion date: Expanded treatment and education program options identified above shall be implemented by **11/1/05**.

Current status: Accomplished.

Strategy 4

Conduct multi-disciplinary reviews at least six times a year, using a case conference model and under the supervision of the medical director, of client progress toward achievement of Inpatient Treatment Plan goals and objectives, targeting areas needing additional support and assigning staff responsibility for specific treatment interventions.

Active Progress:

Dr. William Torrey of Dartmouth has been to Riverview three times this fiscal year (October 13, December 12, and March 7) and has done case conferences on six clients. In addition, 16 internal case conferences discussing challenging cases have been held in the current fiscal year.

Target completion date: Six case conferences will be completed by 7/1/06.

Current status: Completed.

Strategy 5

Reorganize morning rounds to address significant care events since last report, such as the use of PRN medications, restrictive treatments, identification of new problems and any specific interventions that should occur in the next 24-hour period that will further individual treatment.

Target completion date: Completed.

Strategy 6

Strengthen hospital-based supported employment services by:

A. Hiring two additional employment specialists (for a total of six) over the next 12 months who would focus their efforts on obtaining transitional employment placements and community-based employment for extended care clients.

Active Progress: This has been completed.

B. Providing GED preparation and testing services and monitoring their effectiveness in helping clients earn diplomas.

Active Progress: This is an ongoing available service for clients.

C. Collaborating with the Department of Education to improve access to GED services in Maine.

Active Progress: This relationship will be redeveloped by a new client educator who has recently joined the Riverview staff.

Target completion date: Hospital-based employment services will be strengthened by 9/1/05.

Current status: This has been completed.

Performance Indicator: Develop a preliminary treatment and transition plan within three working days of admission

Performance Measure: Percent of preliminary treatment and transition plans developed within three working days of admission

Current Progress: This is monitored monthly and reported in the quarterly report.

Performance Standard: 95% of clients will have a preliminary treatment and transition plan developed within three working days of admission

Current Progress: 100% the 3rd quarter of FY 06

Active Progress:

This is monitored and tracked monthly and is included in the quarterly performance improvement report. Current data shows 100% compliance.

- **Performance Indicator:** Develop and implement an individualized Inpatient

Treatment plan within seven days of admission.

Performance Measure: Percent of plans completed within seven days of admission.

Performance Standard: 100% of clients will have an individualized Inpatient Treatment Plan in the medical record prior to the end of the 7th day of hospitalization.

Active Progress:

This is monitored reported monthly and is included in the quarterly performance improvement report. Current data shows 99% compliance.

Goal 1, Objective 2:

To engage peer support specialists who provide clients with needed supports and help strengthen client-staff relationships in order to diffuse potential tensions and contribute to a positive treatment environment.

Strategies:

Provide fiscal resources to continue the use of peer specialists and identify additional areas of involvement of peer specialists.

Target completion date: Current service contract will be continuously maintained, with the addition of one peer specialist position, by 10/15/05.

Active Progress: The number of peer specialists has been increased by one and maintained at that level.

Performance Indicator: Contacts between clients and peer specialists.

Performance Measure: Percent of clients who have documented contact with a peer specialist during their treatment experience.

Performance Standard:

(a) 80% of clients will have documented contact with a peer specialist during hospitalization.

(b) 80% of all treatment meetings shall involve a peer specialist.

Active Progress:

Both of these are monitored monthly and reported in the quarterly report. Current report period indicates (a) at 100% compliance and (b) at 78%.

Goal 1, Objective 3:

To ensure the appropriate and minimal use of seclusion and restraint practices.

Strategies:

1) Continue reporting seclusion and restraint data through NASMHPD Research Institute protocol.

Active Progress:

This is ongoing, with reports issued monthly by the 15th of the month. Much progress has been made in timely submission of this data to NRI from > 6 months to submitting data by the 15th of the month.

2) Continue Riverview Psychiatric Hospital's commitment to evaluate and monitor all restraint episodes, including those of less than five minutes that are not reportable through NASMHPD Research Institute protocol.

Active Progress:

This occurs daily at the morning meeting between the superintendent, the deputy superintendent over clinical services and the risk manager; as well as at the unit level in dry rounds; and by the treatment team, which reviews and appropriately updates the treatment plan within 72 hours of such an occurrence.

3) Monitor the use of seclusion and restraint practices through oversight by NAPPI Leadership Committee, Medical Executive Committee, Human Rights Committee and Executive Leadership Committee.

Active Progress:

This is ongoing. The NAPPI Committee has been renamed the "Behavioral Response Committee.

4) Continue to conduct high-intensity education into current uses of and alternatives to seclusion and restraint practices.

Active Progress:

This is ongoing, with current emphasis on communication to reemphasize the practices and philosophy of care and treatment of clients in behavioral dyscontrol.

5) Monitor the authorization of PRN medication for the management of behavior.

Active Progress:

The pharmacy has been able to make all prns be on a separate MAR so that it can be monitored more readily. The med nurses file individual slips on each prn given, and record information so it is available for dry rounds in the morning.

Target completion date: All current efforts and actions will be maintained.
Current status: This has occurred and is continuing.

Performance Indicator: Duration of seclusion and restraint incidents

Performance Measure: Total restraint and seclusion hours do not exceed the national mean as reported by the NASMHPD Research Institute

Performance Standard: No more than one calendar quarter outside of compliance measure for any six-quarter period.

Active Progress:

This data is collected and sent to the units as well as to NRI each month. It is included in the quarterly Performance Improvement Report. Over the last 18 months Riverview has never risen above the national mean for hours of restraint use. Seclusion Hours has been above National mean 12 months and below 6 months.

Goal 1, Objective 4

To employ a complement of well-trained, highly supported and supportive staff.

Strategy 1:

Utilize a multi-disciplinary approach to develop and implement an active training plan for all departments and units:

- a) Draft a training plan and circulate it for staff review and comment;

Active Progress:

Due to acute organizational education needs, hospital training has remained the focus with the forensic unit training plan being completed and the civil plan having been deferred until completion of hospital training. Focus has been on Modern Psychiatric Rehabilitation training, recovery training, respect training, DBT skill training and enhanced training addressing effects of trauma.

- b) Conduct staff training and education that includes staff from community programs as participants and/or expert trainers and focuses on issues and topics of special need and interest, such as:

- i) Working with clients who have especially challenging or complex needs;
- ii) Integrating supported employment into client recovery plans;
- iii) Strengthening active treatment skills for Mental Health Workers and Nurses
- iv) Reducing seclusion and restraint practices

Active Progress:

Much progress has been made in this area, and we will continue to offer more training for both RPC staff and the community. RPC has hosted or facilitated seminars for staff and the community including the Respect Seminar, Recovery, DBT, Readiness Assessment, NAPPI, Psychiatric Engagement, Multiple Psychiatric Grand Rounds from Dartmouth, Readiness Development, and Role Recovery.

- c) Conduct a minimum of six internal clinical case conferences each year.

Active Progress:

16 internal case conferences have been conducted at Riverview over the last 12 months ending March 2006.

- d) Conduct a minimum of four external case consultations each year;

Active Progress:

Six external case consultations have been completed over last 12 months ending March 2006.

- e) Maintain a consultant on vocational services through the next six months.

Active Progress:

The vocational consultant, Roberta Hurley, has been retained and is continuing to assist us in this area.

Target completion date: An active training plan will be developed for all departments and units by 7/1/05

Due to acute organizational education needs, hospital training has remained the focus with the forensic unit training plan being completed and the civil plan having been deferred until completion of hospital training.

Strategy 2:

Assess and strengthen staff competencies to ensure fidelity to the principles of psychiatric recovery.

a) Provide regular and supportive supervision and staff development activities to promote demonstrated competencies.

i) Establish unstructured debriefings for staff on each unit with Psychology staff to provide opportunities to discuss and improve understanding of psychiatric recovery principles.

Active progress: Each unit psychologist works with unit staff offering assistance with debriefings, interventions and problem solving. Some units have weekly meetings of MHW and psychologists to help ensure clinical guidance and best practices to deliver quality psychological care to clients.

ii) Establish unstructured debriefings for staff on each unit with assigned members of leadership staff to provide opportunities to discuss and improve understanding of psychiatric recovery principles.

Active Progress: The Risk manager prompts the Superintendent, Deputy Superintendent and Director of Nursing when a treatment plan is updated so they can work with staff to assure all staff understands changes in the treatment plan, and how it supports patient's needs.

iii) Implement a self-study program for staff involving psychiatric recovery literature.

Active Progress: This is in progress.

b) Conduct annual reviews of individual staff performance and competence;

Active Progress:

Annual reviews are not yet being performed consistently (as shown by the table below), and management is currently working to improve this.

c) Initiate corrective action plans, including progressive disciplinary practices, with staff that do not meet minimum levels of competence.

d) Strengthen lines of supervision and accountability with emphasis on local control and accountability at the unit level.

i) Implement clinical nursing supervision plan.

Active Progress:

The plan that was developed on 7/1/05 met with significant difficulties in implementation. A new Director of Nursing was hired in February 2006, and this

person, along with the Deputy Superintendent, has implemented a revised plan. Evaluation of impact is on-going.

ii) Implement staff acknowledgement plan to enhance staff morale.

Active Progress:

Weekly Superintendent Updates, Quality Bullets, and Birthday cards are steps that were implemented by 7/1/05. Reward cards were implemented in 2/06. Quality Champions program will be implemented by 6/1/06.

Target completion date: 100% of Nursing and Mental Health Worker staff will have a performance review documenting displayed competencies by 7/1/06.

<u>INDICATOR</u>	FINDINGS	
Employee Performance Evaluations expected to be completed within 30 days of the due date.		
Jan 2006 (November evals)	17 of 33	52%
Feb 2006 (December evals)	16 of 29	55%
Mar 2006 (January evals)	14 of 29	48%

Current status: This continues to be a work in progress.

Strategy 3:

Strengthen Labor-Management relations:

a) Utilize additional support of DHHS to address labor management issues;

Active Progress:

Lucia Nadeau, Director of Human Resources at Riverview utilizes her knowledge of the state system to invite appropriate guests to Labor Management meetings, such as Workers Compensation Staff.

b) Convene weekly Labor-Management meetings;

Active Progress:

The frequency of these meetings has been decreased to monthly at the request of the unions.

c) Reduce utilization of mandated shifts;

Active Progress:

There has been progress in decreasing mandated shifts over the last year; there have been occasional mandates when acuity has been high, (reported on the quarterly report)

i) Conduct weekly monitoring of mandated shifts use.

Active Progress:

Human resources monitors and reports to the Superintendent weekly;

Target completion date: A total of 42 Labor-Management Meetings will be conducted by 7/1/06.

Active Progress: Although originally weekly, Union representation requested a reduction of frequency to monthly.

AFSCME labor management meetings have been held since June 2005

MSEA labor management meetings have been held since June 2005

Performance Indicator: Range of active treatment

Performance Measure: Percent of clients for whom rehabilitation support is planned, provided and documented for primary functioning skill

Performance Standard: 95% of clients who have assessed needs in the area of primary functional skill rehabilitation will have the needs documented on the treatment plan and treatment or services provided.

Active Progress: The protocol has been developed but implementation has been variable. Outside training has been purchased through Boston University Outreach Education on Modern Psychiatric Rehabilitation, Role Recovery, implemented in 11/05 and is ongoing with monthly sessions.

Objective 5:

To assure that client rights are consistently understood, respected and monitored by staff and clients in ways that strengthen the consumer-centered nature of inpatient psychiatric care at Riverview Psychiatric Center.

Strategy 1:

Through a comprehensive critical incident and reporting plan, maintain and regularly review reports of patient incidents, grievances and use of restrictive practices to discern and correct undesirable trends.

Active Progress: Quarterly reports are completed and distributed as well as placed on the Riverview Web site.

Target completion date: A minimum of four Quarterly Performance Improvement Reports will be developed and distributed-each year.

Current Status: This has been accomplished.

Strategy 2:

Develop and maintain a web page that provides the following, easily accessible information:

- a) Rights of Recipients;
- b) Client Handbook;
- c) Visitor Guidelines;
- d) How to file a suggestion or complaint, including a description of grievance procedures available to all healthcare recipients;
- e) How to ask for information;
- f) Information about diagnoses;
- g) How to contact NAMI and other advocates or advocacy organizations;
- h) Finding peer supports in the community;
- i) Current and past Quarterly Performance Improvement Reports;
- j) Committee Minutes: Advisory Board, Executive Leadership, Human Rights, Labor Management, Safety, NAPPI Leadership.

Target completion date: An Internet-based web page will be developed for the hospital with the elements noted above by 7/1/05.

Current status: Completed by 10/05

Strategy 3:

Establish an independent advocate position.

Target completion date: A contract for advocacy services will be implemented by 10/15/05.

Current status: RPC has contracted for advocacy services; and the advocates began in 2/06.

Target completion date: Human Rights Committee will complete review and revision by 8-1-05.

Current status: This is complete.

Strategy 4:

Continue to have the grievance process monitored by the Human Rights Committee.

Target completion date: Human Rights Committee will continually monitor grievance process and complete an annual self-evaluation.

Current status: HRC committee receives and reviews non-identifiable grievances monthly, grouped by category to assist the group in identifying patterns or concerns.

Strategy 5:

Capacity to consent for treatment shall be assessed by the treating practitioner at each treatment plan review and documented in a medical progress note.

Target completion date: Medical staff will complete a peer review of these assessments twice per year, with the first review 12/15/05, documenting compliance levels and initiating quality of care improvement strategies.

Current status: This information is collected and documented on the treatment review form. Additional tracking responsibility for this is assigned to the UR Nurse, with noted exceptions to be brought to the attention of the medical director.

Performance Indicator: Client grievances.

Performance Measure: Response to client grievances within 5 days.

Performance Standard: 98% of client grievances are responded to within 5 days

Active Progress: This is monitored by the peer support service. It is reported monthly and included in the quarterly report. During the period from January through March 2006, 94 of 99 grievances (95%) were responded to within the five-day timeframe.

Goal 2

Ensure that Riverview Psychiatric Center provides Maine citizens with high-quality mental health inpatient treatment services within the least restrictive and most appropriate treatment setting.

Objective 1:

To conduct pre-admission assessment and planning to achieve hospital admissions that are appropriate, timely and necessary to meet acute psychiatric care needs.

Strategy 1:

Riverview Psychiatric Center and other Department representatives, with input from community providers, will develop, implement, assess and revise hospital admission procedures designed to:

a) Maintain the hospital's role as a tertiary care facility within the mental health continuum;

Active Progress: The Admission Department and the Medical Director collaborate with all referring agencies to elicit accurate information when accepting clients for admission.

b) Identify maximum benefit date of hospitalization;

Active Progress: Psychiatrists are documenting this at admission, and the UR nurse is tracking it.

c) Coordinate with referral sources and community providers their expectations of hospitalization;

Active Progress: This occurs within the admissions department, in doctor-to-doctor and nurse-to-nurse interactions, and through the initial continuity of care meeting.

d) Anticipate length of stay at time of admission; see response to (b) above;

e) Utilize procedures to request intensive support from community regional team leaders in determining and securing the community service resources needed for especially complex situations;

Active Progress: The weekly discharge planning meetings are assisting with this process. The Superintendent and Deputy Superintendent of Clinical Services are adept at engaging community providers in obtaining necessary services to assist clients in more timely discharges.

f) Continue referral of people inappropriate for Riverview admission (people with a primary diagnosis of mental retardation or other developmental disabilities, brain injury, dementia or substance abuse) to other treatment settings.

Active Progress: This is an ongoing process.

Strategy 2:

Hospital staff will offer on-site consultation and training to community providers, including jails and prisons, upon request, to facilitate stabilization of clients in their environment of need.

Active progress: Therapeutic recreation staff, psychologists and PSD's have offered individual training and consults to work with community providers as difficult clients transition, and with jails in transitioning clients or in stabilizing clients.

Target completion date: A procedure will be established and implemented, with jail and prison staff oriented in how to request training by 7/1/05.

Current status: Completed.

Strategy 3:

A continuity of care meeting will be convened within 2 business days of admission for all clients, including forensic clients who are referred by jails, to clarify expectations and the circumstances leading to hospitalization.

Active Progress: This is happening throughout the facility. There is difficulty in having a client see the benefit of jail employees participating in the care plan.

Target completion date: Quarterly Performance Improvement report will monitor implementation of current procedures by 10/15/05.

Current status: This is being monitored monthly and reported in the Quarterly Performance Improvement Report.

Performance Indicator: Admissions to Riverview Psychiatric Center

Performance Measure: Percent of admissions that meet all legal admission criteria.

Performance Standard: 100% of admissions will meet all legal criteria for admission.

Active Progress: This standard has been achieved.

Performance Indicator: Readmissions to Riverview Psychiatric Center

Performance Measure: Percent of admissions within 30 days of previous discharge that meet all established admission criteria

Performance Standard: Percent of readmissions not more than the national mean, as reported by the NASMHPD Research Institute

Active Progress:

From July 05 through December 05 Riverview remained at or below the national percentage of clients who were readmitted within 30 days, except for the month of September 05 when there was a spike in readmissions.

Objective 2:

To coordinate with community providers the timely transition into appropriate community placements of civil and forensic clients who no longer need hospitalization.

Strategy 1:

Train key staff in the “Transition Planning Guidelines for People Hospitalized at Riverview Psychiatric Center” policy, including the roles, functions, responsibility and authority of Continuity of Care Managers and Community Support Workers.

Target completion date: 85% of Program Service Directors and Continuity of Care Managers will receive training in the guidelines by 6/15/05.

Active Progress:

PSD’s and CCM have received such training. As of October 1, 2005, 100% had received orientation and training.

Strategy 2:

Review transition-planning guidelines at least annually and make whatever revisions are necessary to improve the timely transition of clients into appropriate community placements.

Target completion date: Guidelines will be assessed and revised as necessary by 7/15/06.

Active Progress:

Weekly meetings with providers and community supports. A community survey was completed in 2005. A review of processes will be a priority as a Director of Continuity of Care is hired at the hospital. Advertising since 2/06.

Strategy 3:

Reduce hospital stays of current civil clients deemed ready to transition from hospital by:

a) Identifying a community services liaison to quickly identify communication issues and strategies that will address any service barriers that are preventing timely

transitioning of civil clients into the community and may be leading to rapid hospital readmission of previous client.

- b) Creating a Service Plan of Operation for the Continuity of Care Department, identifying discharge planning, community support, assessment, service planning, active treatment provision and other key functions and orienting all staff to these procedures.
- c) Conducting periodic status reviews of civil clients ready for transition to community placement.
- d) Conducting a case review for each client readmitted within 30 days to identify specific supports, problematic behaviors, level and type of access to community treatment and other issues that may contribute to re-hospitalization, with results reported through Riverview Psychiatric Hospital's Performance Improvement Program.
- e) Increasing participation of community providers in treatment planning and treatment planning reviews and reporting the effectiveness of this activity through the Performance Improvement Program.
- f) Implementing a revised access protocol for community providers to increase participation in hospital-based service planning.
- g) Maintaining continuity of care with community providers during unit transfers through a clearly defined transfer policy.
- h) Convening staff and community provider representatives in a minimum of four Case Resolution Conferences annually to develop unique community care solutions for persons at risk of continued hospitalization.
- i) Establishing "post-discharge readiness" days as a performance measure for each region.

Active Progress:

The above actions steps have all been implemented since 8/05.

Target completion date: Average lengths of stay will be monitored through quarterly Performance Improvement reports beginning 6/15/06. A discharge readiness report will be maintained and updated weekly identifying discharge readiness, needs and action steps by 6/1/05.

Current status:

These reports are being generated on a regular basis and have been since 6/05. All of the strategies are being utilized to improve the ability to serve clients in the most appropriate and least restrictive environment.

The discharge readiness, needs and action steps are updated weekly on the unit and are monitored by the Deputy Superintendent of Clinical Services and reported in the Quarterly report.

Strategy 4:

Identify unmet needs requiring resource development through the Riverview discharge reports for those clients who do not have an ISP or community support worker. The appropriate regional office will be responsible for tracking any unmet needs upon discharge.

Current Status: The RPC Continuity of Care staff are responsible for reporting this information to the CDC, who will enter the information in EIS, using the ISP RDS format. It will be considered part of the compliance with paragraph 74 reporting.

Strategy 5:

Reduce hospital stays for forensic NCR clients deemed ready to leave Riverview Psychiatric Center by:

a) Aggressively assessing appropriateness for expanded court conditions for rehabilitation toward community transition.

Active progress: A total of 18 petitions were on the court docket at the last hearing, which is the highest number on record.

b) Transferring responsibility for operation and clinical oversight of Homestead to Riverview to provide transitional services for forensic clients.

Active Progress: Completed.

c) Re-organizing professional services to supplement/coordinate a shared service model where hospital forensic staff provide some of the transitional care services to those in the community.

Active Progress: Capitol clinic- forensic liaison has been identified. , Hospital support services to this population through the clinic are occurring.

d) Exploring and assessing electronic monitoring options which may have utility for transitioning forensic clients into the community.

Active Progress: An electronic monitoring data system device was presented to the forensic team and leadership group for consideration in January 2006. The hospital is continuing to explore other options.

Target completion date: By October 2005, begin ongoing process of transitioning select NCR clients (those assessed to be appropriate, and having the necessary modified release authorizations) into the community on modified release status through use of private and hospital services.

Current status: This has been initiated.

Strategy 6:

Collaborate with Mental Health Team Leaders to develop discharge plans for forensic clients and provide discharge plans to the placement facility a minimum of 24 hours prior to discharge.

Active Progress: This is ongoing,

Target completion date: Beginning with the first report produced after 7/15/05, Riverview's Quarterly Performance Improvement Report will address implementation of current procedures to develop and share discharge plans for forensic clients.

Current status: This has been implemented.

Performance Indicator: Transition of clients from Riverview Psychiatric Center into the community upon determination that maximum benefit has been received from inpatient care

Performance Measure: Percent of individuals transferred into the community post determination that maximum benefit has been received from inpatient care

Performance Standard:

75% of clients are transitioned within 7 days of maximum benefit from inpatient care.

90% of clients are transitioned within 30 days of maximum benefit from inpatient care

100% of clients are transitioned within 45 days of maximum benefit from inpatient care.

	7 Days	30 days	45 days
Oct-05	60%	80%	80%
Nov-05	43%	71%	79%

Dec-05	50%	63%	75%
Jan-06	50%	75%	92%
Feb-06	25%	56%	63%
Mar-06	25%	75%	75%

Objective 3:

To develop additional community-based resources necessary to support the placement of all class members who no longer require hospitalization into community settings that are appropriate to their needs.

Strategy 1:

With the support of NASMHPD National Technical Assistance Center, develop and deliver complementary joint hospital and community education, training and technical assistance designed to increase local program capacity. Deliver effective community-based services to complex and challenging individuals who may be self-injurious or present behavioral difficulties.

Target completion date: By 9/1/05, develop and deliver training.

A work group comprised of AMHS staff (including Riverview), providers, and consumers organized a conference on April 24, 2006, “A New Understanding of Distress and Suicidal Behavior—Changing our Approach Together: A Maine System’s Challenge.” On-going technical assistance and collaboration is planned as a follow up to this conference, to be coordinated by the regional mental health team leader.

Strategy 2:

Develop and expand appropriate community-based forensic supports by utilizing a jail/hospital liaison to consult with jails and community hospitals to support individuals who are at risk of hospitalization.

Target completion date: A forensic transition support plan will be developed and implemented by 9/15/05.

Active progress: Liaisons for each jail and Riverview have been assigned. Implementation of the rapid stabilization process to improve access and after care coordination was implemented on 1/1/06.

Performance Indicator: Training to increase local program capacity to support challenging clients after transition into the community

Performance Measure: Percent of participants who indicate increase in their capacity to support and maintain challenging clients transitioned from Riverview Psychiatric Center into the community

Performance Standard: 85% of participants indicate that training offers “good” or “excellent” support in maintaining challenging clients in the community

Active Progress:

A variety of training on Trauma, DBT, Respect, Psychiatric Rehabilitation and recovery has been delivered, with a total of 10 sessions over the last 9 months. 91% of the evaluations reflect a “good” or “excellent” response.

Goal 3:

Administer Riverview Psychiatric Center in a professional manner that ensures delivery of appropriate patient care within available fiscal resources.

Objective 1:

To monitor, evaluate and improve hospital functions through consistent and timely performance reporting.

Strategy 1:

Implement a Performance Improvement Program that allows RPC to continuously monitor and track improvements in hospital performance in essential areas, including: development and implementation of individualized Inpatient Treatment Plans; PRN medication utilization patterns; frequency of medication errors; delivery and effectiveness of individualized client services; client elopements; client and staff injuries; receipt of appropriate, atypical generation of antipsychotic medications. (A description of the Performance Improvement Plan currently in place is included as Attachment A to this Chapter. The process changes as additional strategies for improvement are identified and incorporated into that plan.) The results of hospital licensing reviews, complaint investigations, inspection of care reports and accreditation reviews will also be utilized for monitoring and evaluation purposes.

Active Progress:

Riverview has implemented monitoring processes in essential areas monthly; and a formal report is compiled each quarter. There is an active Quality Council to help steer the process.

Strategy 2:

Identify client needs for services upon discharge from Riverview Psychiatric Center through the development of transition plans which: a) become a component of the Individual Service Plan (ISP); or b) are collected by Continuity of Care Managers, for clients who choose not to have an ISP.

Active Progress:

Implemented and on going.

Strategy 3:

Conduct administrative morning report twice per week to address cross-discipline and program issues, significant trends in treatment, identification of needed supports or acute organizational challenges.

Active Progress:

Implemented and on going.

Strategy 4:

Conduct monthly Superintendent Town Hall Meetings to communicate hospital vision and develop support for continued change and improvements within RPC.

Active Progress:

Monthly Town Hall Meetings have been conducted for the last 18 months.

Target completion date: All activities designed to assess and enhance Riverview Psychiatric Center's institutional performance will be continually reviewed and refined throughout the plan period.

Performance Indicator: Medication errors

Performance Measure: Not more than the national mean, as reported by the NASMHPD Research Institute

Performance Standard: Not more than one calendar quarter above the national mean within any six-quarter period

Performance Indicator: Client elopements

Performance Measure: Not more than the national mean, as reported by the NASMHPD Research Institute

Performance Standard: Not more than one calendar quarter above the national mean within any six-quarter period

Performance Indicator: Client Injuries

Performance Measure: Not more than the national mean, as reported by the NASMHPD Research Institute

Performance Standard: Not more than one calendar quarter above the national mean within any six-quarter period

Performance Indicator: Clients receiving appropriate, atypical antipsychotic medications

Performance Measure: Not more than the national mean, as reported by the NASMHPD Research Institute

Performance Standard: Not more than one calendar quarter the national mean within any six-quarter period

Active Progress:

All of the above indicators are reported as requested in the quarterly reports. See part IV of this report.

III Updates on Cost of Plan Implementation

A. Cost of Consent Decree Plan Implementation

Funding Resources FY 06 and 07

Service	Basis	State Funds	State Seed	Total 06	Total 07	Comment / Update
Continuity of Care Program Managing Care	Transition/start-up costs for planning and implementing a system for managing care		\$250,000	\$250,000	TBD	This work is governed by P.L. 2005, c. 457, part PP
Consumer Councils	8 regional and 1 statewide council including 3 positions to staff the 9 councils, logistical and training costs	\$323,000		Self funded	\$323,000	
Provides additional capacity for Warm Lines	Peer run warm lines	\$90,000			\$90,000	Continues funding \$125,000 of '06 contract and adds \$90,000
Consumer involvement in licensing reviews	The equivalent of 6 FTE's – reimbursement mechanism to be developed by the Consumer Council					This cost is combined with the Consumer Councils
Develop crisis residential units to serve as diversion from the hospitals	Add/increase medical staff and other staff or supports in Crisis Residential Units	\$230,950			\$230,950	Provides funding for CRUs, including observation beds, as recommended by Court Master
Residential Development	Specialized individualized housing and supports (up to 8 clients)	\$109,000	\$640,000		\$749,000	Based on 12 months x \$7,000 per client per month
ACT Forensic Team	Provides a comprehensive, community-based, evidence-based team service to forensic clients	\$121,222 for ½ time position to manage ACT development and process and \$6,222 for Dorothea Dix clients	\$115,237 for Dorothea Dix ACT		\$242,681 Plus self-funding	Funds progressive treatment program through ACT teams at Riverview PC and Dorothea Dix PC through

		not MC eligible				Medicaid and non-Medicaid funds.
Geriatric Mental Health Services	Additional funding services for older persons with mental illness/medical issues		\$360,000		\$360,000	
Additional funding						
Advocacy Initiative Network	Will develop consumer leaders to be on Councils	\$100,000			\$100,000	
Vocational supports	To increase vocational supports	\$200,000			\$200,000	Part of the Court Master's response to the CD plan
Community Supports/Non-Cats/Class Members		\$178,000			\$178,000	
Total		\$1,358,394	\$1,365,237	\$250,000	\$2,473,631	

B. Paragraph 282

By court order dated November 7, 2004, class members living in assisted living facilities that are licensed by DHHS have the right to a grievance process of the sort described in paragraph 18, 19 and 21 of the Settlement Agreement. The Rights of Recipients of Mental Health Services apply to facilities that are licensed to provide mental health services, whereas, previously, residential facilities that did not provide mental health services were governed by DHHS's Regulations Governing the Licensing and Functioning of Assisted Housing Programs. *Me. Dep't of Hum. Serv.*, 10-144 *CMR* §113 (eff. Sept. 1, 2003). The latter regulations include requirements for a grievance process and authorize DHHS to investigate complaints regarding alleged violations or noncompliance with the rules, but the rules do not address violations of the terms of the Settlement Agreement.

DHHS submitted a change to the assisted housing rules that requires those facilities to provide a grievance process covering claims by class members that the provider has violated the terms of the Settlement Agreement or any other applicable law or regulation. By statute, any changes to the assisted housing rules are deemed major substantive and, therefore, require Legislative approval prior to final adoption. The Legislature has approved the rule change and Governor has signed the resolve into law as an emergency measure. Please see below for next steps.

- 1) DHHS Office of Licensing and Regulatory Services will publish notice of the rule change in the newspaper on May 3, 2006.
- 2) DHHS Office of Licensing and Regulatory Services and DHHS Office of Adult Mental Health Services will send a joint memo to all assisted living facility providers to advise them regarding the rule change. The memo will advise providers what steps to take regarding the grievance process as it applies to Class Members served by their facility. Providers will be advised to contact Disability Rights Center for assistance or advocacy needed when helping a consumer file a grievance. Please see attached (Attachment 31) draft memo. Projected date to send the memo is May 5, 2006.
- 3) DHHS Office of Licensing and Regulatory Services will hold trainings for assisted living facility staff. DHHS Office of Adult Mental Health Services will provide trainees with:

- Copies of DHHS Rights of Recipients of Mental Health Services Grievance Manual
- Copies of a brief Grievance Process Summary that will define the Levels of the grievance process and define what steps providers need to take to be in compliance with the process.

Projected completion date of training is set for June 3, 2006.

IV



Performance Improvement Report

Third Quarter

SFY 06

January, February and March

○ David Proffitt, Superintendent

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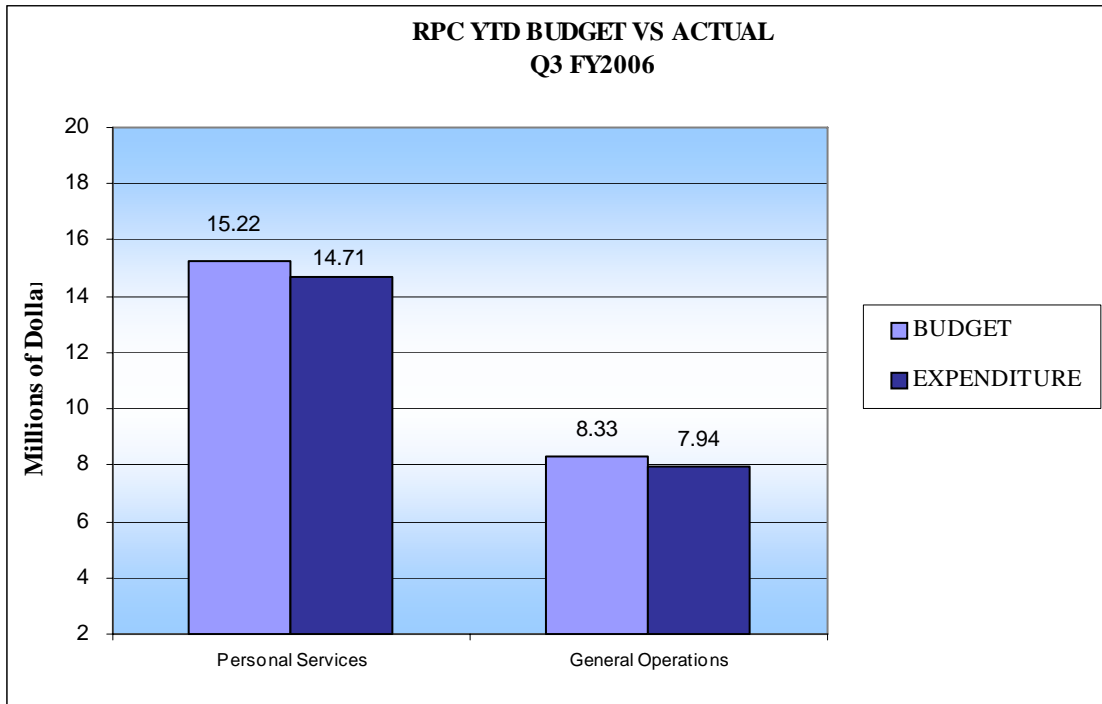
Comparisons with National Data (COPSD)

Introduction:

Riverview Psychiatric Center (RPC) has the **mission** to provide state of the art care to individuals with serious and persistent mental illness in Maine. RPC's **vision**, in collaboration with the community, will be a center for best practice, treatment, education and research for individuals with serious and persistent mental illness. The RPC **values** are to always treat clients with Respect and Dignity, Patients First, and Caring and Compassion.

The Riverview Process Improvement Quarterly report does consider the aims for improvement and process changes by reviewing departmental quality indicators, high risk, high volume information and national indicator information that displays how RPC compares to like facilities throughout the country. Most importantly, it describes the steps RPC intends on undertaking, to constantly improve.

Management of Financial Resources



For the second straight year, the hospital is operating within its budget, through aggressive management of all contractual services via fiscal and programmatic accountability.

Management of Human Resources

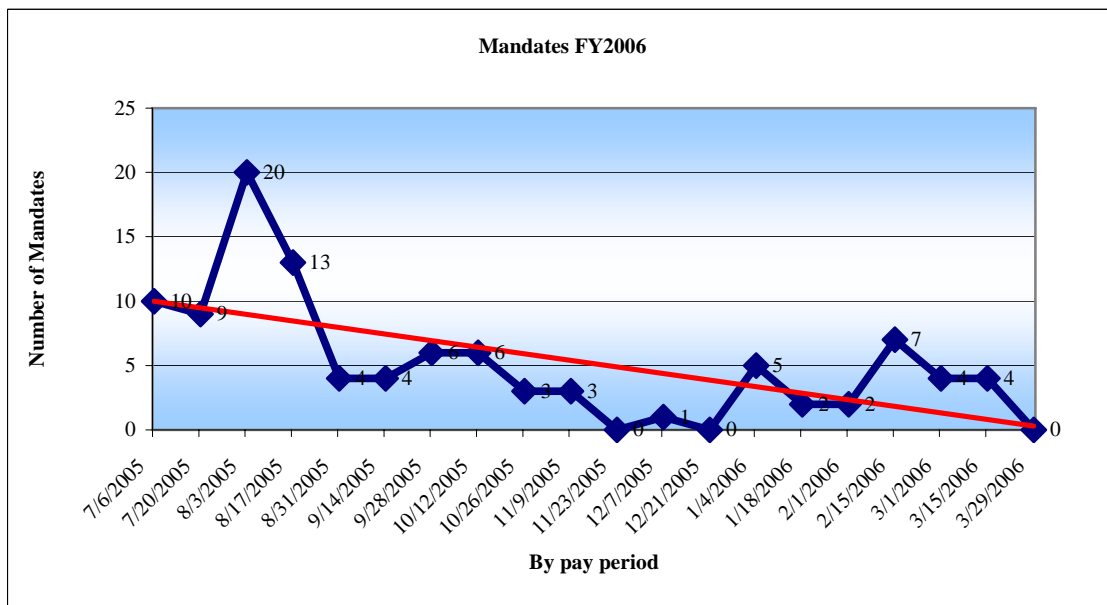
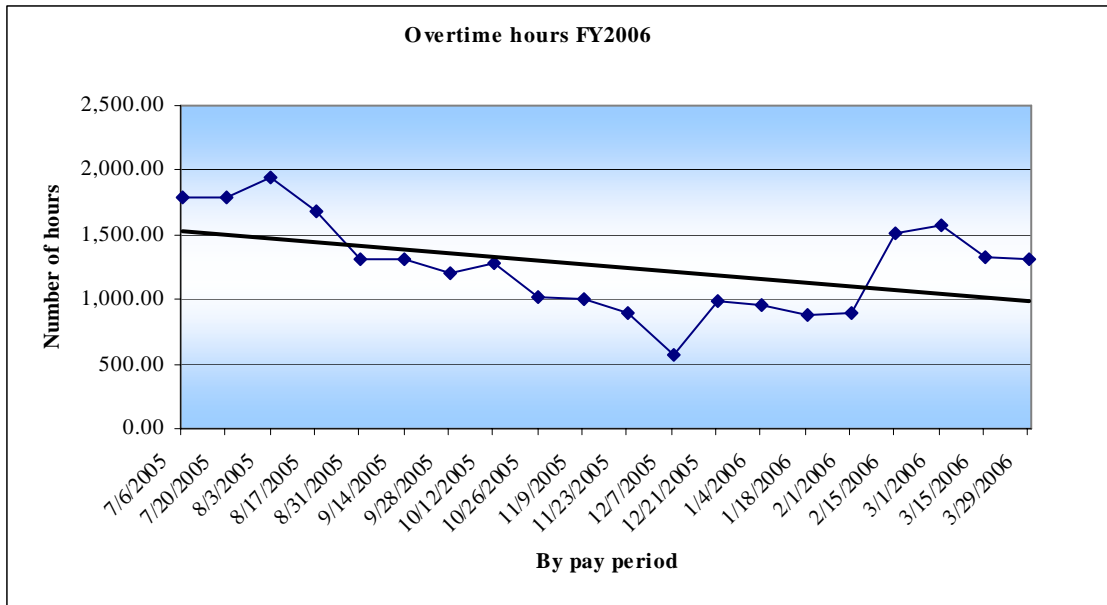
Aspect: Performance Evaluations

Overall Compliance: 52%

INDICATOR	FINDINGS		<u>TARGET PERCENTILE</u>
Employee Performance Evaluations expected to be completed within 30 days of the due date.			
Jan 2006 (November evals)	17 of 33	52%	85%
Feb 2006 (December evals)	16 of 29	55%	85%
Mar 2006 (January evals)	14 of 29	48%	85%

Human Resources will continue to monitor and report on a regular basis to Executive Leadership concerning the progress of compliance.

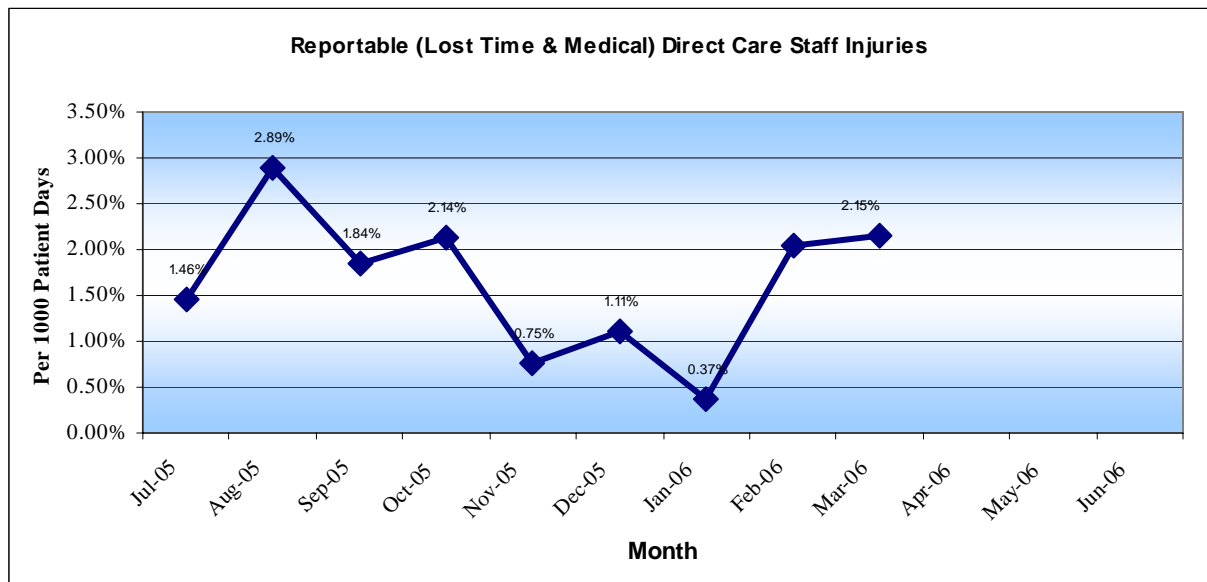
Aspect: Staff Overtime and Staff Mandates



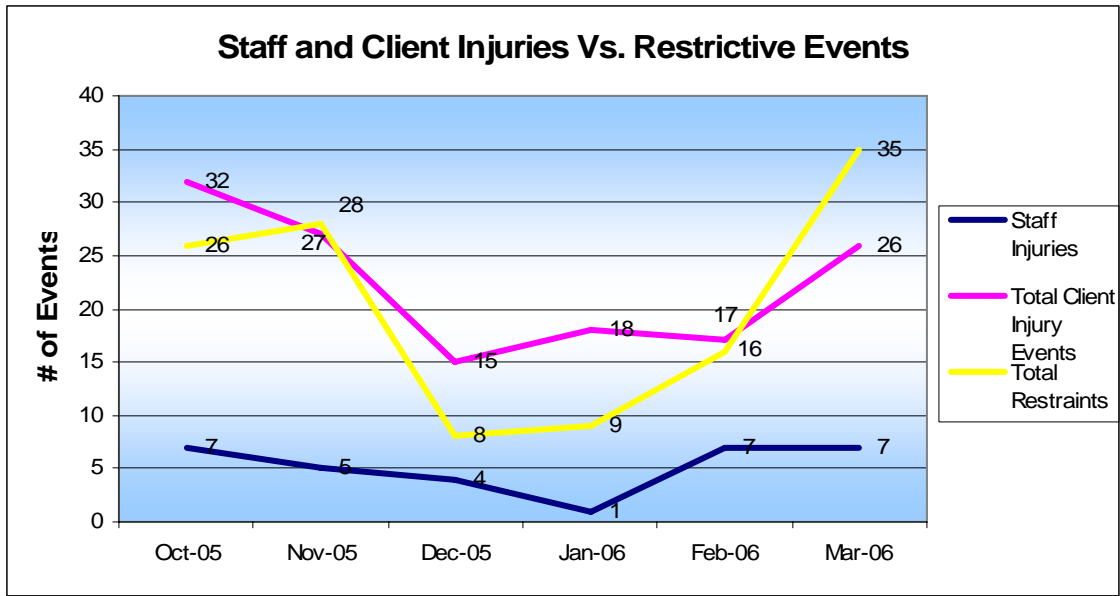
Both Staff Overtime and Mandated shifts have increased from last quarter. This is attributed primarily to having two clients transferred from MSP who required 2:1's staffing during most of this quarter. Additionally, several employees re-applied for intermittent Family Medical Leave resulting in overtime or mandates.

A multidisciplinary Staffing Oversight committee was formed to look at ways to improve mix of staffing on the units as well as reduce overtime utilization and decrease mandates.

Aspect: Direct Care Staff Injury Lost Time and Medical Care



This quarter noted an increase in direct care staff injuries from an overall of 1.33% for last quarter to 1.52% for this quarter. This percentage represents 13 direct care staff that sought medical treatment or lost time from work, as compared to 11 last quarter. Training continues for staff on new techniques and recommendations by the Behavioral Response Committee. Compared to the same time period last year (Jan 05 - Mar 05) when RPC had an average of 1.66% of direct care injuries per 1000 patient days. Staff injuries from combative clients continue to remain the single major cause of lost time and medical injuries. The Behavioral Response Leadership Committee is developing additional teaching modules to increase unit leadership during emergency situations; to increase confidence of employees in handling behavioral situations in the most therapeutic and safe manner.



The hospital continues to emphasize in its training to staff, that restraint events present the greatest risk of injury to staff and client alike. A great deal of effort by the hospital administration, Staff Development and Education, NAPPI training is directed toward alternatives to restraints, redirections, verbal engagements, and therapeutic interventions.

Professional and Organizational Development

Aspect: Hospital Orientation

Overall Compliance: 100%

INDICATORS	COMPLIANCE		THRESHOLD
All new staff hired by the Riverview Psychiatric Center will complete an Orientation to the hospital prior to assuming their duties.	12 of 12	100%	100%

Findings: In the 3rd quarter of 2006 Riverview Psychiatric Center hired 13 state employees. One employee resigned prior to finishing orientation.

Actions: Staff Development will work with Human Resources in completing Orientation.

Infection Control

Aspect: Hospital Infection Control

Overall Compliance: Hospital average (36 months): 2.87

Indicators Jan., Feb., Mar. 2005	Number	Rate	Threshold Rate
Hospital Acquired (healthcare associated) infection rate, based on 1000 patient-days	20	2.52	2 standard deviations (5.26)

Findings: Infection rate is obtained by total house surveillance, accomplished by chart reviews, review of antibiotic prescribing (for infections or prophylaxis) and clinical staff reporting. According to the Maine CDC, reported cases of influenza and influenza like illness have peaked during late March throughout Maine and New England.

Problem: None noted.

Status: Hospital acquired infection rate for this period was 2.52, slightly below our 36-month average and well within the 2 standard deviation threshold of action

Actions: Influenza and influenza-like illnesses (ILI) among clients monitored. Staff and client education continued from last quarter through email updates and new signage. Hand hygiene and respiratory etiquette continue to be stressed to clients and staff. Information regarding general infection control information was sent to staff by the Medical Director and the Infection Control Nurse regarding general infection control and standard precaution information.

Medical Staff

Aspect: - Internal Peer Review of Medical Staff Documentation of Physical Exam

Overall Compliance: 83%

January, February, March, 2006			
Indicator	Findings	Compliance	Target%
Total documentation of physical exams reviewed will meet minimum passing requirements as detailed in the "physical exam peer review form."	18 of 21 notes met minimum requirements	86%	90%
All individual practitioner's documentation of physical exams will meet minimum passing requirements.	4 of 5 individuals met minimum requirements	80%	100%

Findings: The documentation of individual physical exams continues to fall below the target compliance rate of 90%. It is significantly improved from last quarter score of 72%. One after-hours practitioner fell below standard, accounting for the bulk of the variance.

Problem: One practitioner's performance below expectations.

Status: Overall compliance dropped this quarter from 86% to 83%.

Actions: Documentation of physical exams will be discussed at the after-hours medical staff meeting on April 11, 2006. Continue to monitor and discuss at Medical Staff meetings. The one practitioner that was below standard will be counseled by the Medical Director.

Medical Staff

Overall Compliance: 100%

Aspect: Staff Prescribing Errors

January, February, March 2006			
indicator	Findings	Compliance	Target %
No medical staff members will have more than two prescribing errors in any given month.	None in Jan 1 in Feb 1 in March	100%	100%

Findings: There were two prescribing errors by two practitioners in the 3rd quarter. Neither error resulted in significant negative client outcome

Problem: None noted.

Status: Medical staff continues to have very low levels of prescribing errors.

Actions: Continue to monitor

Medical Staff

Aspect: Review of Medical Staff Progress Notes

Overall Compliance: 98%

January, February, March, 2006			
Indicator	Findings	Compliance	Target %
Total progress notes reviewed will meet minimum passing requirements as detailed in the "progress note peer review form."	105 of 109 notes met minimum requirements	96%	90%
All individual practitioner's progress notes will meet minimum passing requirements.	11 of 11 individuals met minimum requirements	100%	100%

Findings: Four progress notes out of 109 reviewed in the third quarter fell below the passing threshold of 90%. Psychiatric staff is performing very well on this monitor.

Problem: None noted.

Status: The overall compliance went up from 95% to 98%

Actions: Continue to monitor.

Medical Staff

Aspect: Appropriate use of typical antipsychotics in psychotic disorders

Overall Compliance: 100%

January 2006			
Indicator	Findings	Compliance	Target %
All use of typical antipsychotic monotherapy will meet agreed upon clinical indications	7 clients rec'd 7 clients met clinical criteria	100%	100%
February 2006			
All use of typical antipsychotic monotherapy will meet agreed upon clinical indications	9 clients rec'd 9 clients met clinical criteria	100%	100%
March 2006			

All use of typical antipsychotic monotherapy will meet agreed upon clinical indications	9 clients rec'd 9 clients met clinical criteria	100%	100%
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Findings: Use of typical antipsychotic monotherapy increased slightly over the 3rd quarter

Problem: No problems detected. Medical staff is prescribing typical antipsychotics appropriately.

Status: All clients who received only typical antipsychotics (and no atypicals) met pre-approved clinical criteria.

Actions: None needed; continue to monitor.

Medical Staff

Aspect: Monitoring for IV Sedation in Portland Clinic

Overall Compliance: 100%

January 2006			
Indicator	Findings	Compliance	Target%
Sedation patients will have an O2 sat on room air of 92% or greater before going to recovery	13 pts sedated Lowest baseline SAT 94% Lowest final SAT 94%	100%	100%
February 2006			
Sedation patients will have an O2 sat on room air of 92% or greater before going to recovery	20 pts sedated Lowest baseline SAT 92% Lowest final SAT 92%	100%	100%
March 2006			
Sedation patients will have an O2 sat on room air of 92% or greater before going to recovery	28 pts sedated Lowest baseline SAT 93% Lowest final SAT 92%	100%	100%

Findings: 61 clients received sedation services in the quarter. All clients had their oxygen saturations (SAT) at or above the threshold prior to going to the recovery room.

Problem: No problem detected.

Status: All clients receiving IV sedation had adequate oxygenation prior to leaving operatory for the recovery room.

Actions: Continue to monitor 02 SATs both pre-op and prior to admission to recovery. Continue to report at monthly staff meeting and send quarterly report to the Medical Director. Add the time documentation to the next quarter at expectation threshold 100%.

Medical Staff

Aspect: Capitol Community Clinic- Tracking Forensic Clients

Compliance: 100%

Indicator	Compliance	Findings	Threshold
Track forensic client psychiatric appointments to ensure compliance with court	All community forensic patients will be seen as mandated by court.	98% compliance with court mandated psychiatric appointments.	100%

Findings: January 2006: 20 scheduled appointments with the psychiatrist: 31 scheduled appointments with the nurse practitioner; February 2006: 26 scheduled appointments with the psychiatrist: 19 appointments with the nurse practitioner; March 2006: 24 scheduled appointments with the psychiatrist: 23 scheduled appointments with the nurse practitioner;

Status: 98% compliance with court mandated psychiatric appointments

Problems: 3 missed appointments in January due to physical illness

Actions: All 3 appointments were rescheduled to February 2006. Nursing

Nursing

Aspect: Seclusion and Restraint Related to Staffing Effectiveness

Overall Compliance: 97%

Indicators	Findings	Compliance	Threshold Percentile
Seclusion/Restraint related to staffing effectiveness:			
1. Staff mix appropriate	76 of 76	100%	100%
2. Staffing numbers within appropriate acuity level for unit	76 of 76	100%	100%
3. Debriefing completed	66 of 76	87%	100%
4. Dr. Orders	76 of 76	100%	100%

Findings: All staff effectiveness indicators are at 100% with the exception of debriefing

at 87%. The average is 97%

Problem: Staff debriefing continues to be below threshold. The problem is primarily on two of the four units. Of the ten missing debriefings, one unit had eight, and another unit had two. This is relative to the volume of events on the respective units.

Status: Compliance has increased for the indicator of staff debriefing from 78% to 87 %.

Actions: A new debriefing protocol was developed last quarter. Each time a debriefing is not completed, the Risk Manager notifies the PSD, Nurse IV and Nurse who signed the incident report to have the debriefing sent to the risk manager. Next quarter a copy will be requested to be sent to the ADON as well.

Nursing

Aspect: Pain Management

Overall Compliance: 97%

Aspect	Indicator	Findings	Compliance	Threshold
Assessment	Assessed upon admission.	105 of 106	98%	85%
	Assessed using pain scale.	46 of 47	98%	95%
Pre-administration	Assessed using pain scale	963 of 979	98%	95%
Post-administration	Assessed using pain scale	911 of 979	93%	95%

Findings: All admissions are assessed using the pain scale upon admission. Of the 106 charts audited upon admission, 47 identified pain as being present. Pain assessment data continues to be collected weekly from each unit for every client receiving PRN pain medication for the assessment of pre and post administration pain level. Again this quarter, only one of the audited charts assessed pain as being present upon admission, but did not use the pain scale to rate the level of pain. All aspects were above threshold with the exception of using the pain scale for post-administration of a pain medication.

Problems: One audited chart (client refusal) that did not rate the pain upon admission.

Status: Pain assessment upon admission decreased from 100% to 99% due to the one chart not in compliance. Assessment utilizing a pain scale increased from 86% to 98%. Remaining indicators reflect the assessment and reassessment of pain pre and post administration of PRN pain medication.

Actions: Pain scales were added to all PRN stickers, to prompt the documentation of the assessment using the pain scale. A competency based training on the assessment and reassessment of pain to include utilization of the pain questionnaire was done with all

RNs by the Nurse IV or Nurse Educator.

Nursing:

Aspect: Chart Review

Overall Compliance: 81 %

	Indicator	Findings	Compliance	Threshold Percentile
Universal Assessment	Universal Assessment completed by RN within 24 hours.	64 of 67	96%	100%
	Sections completed/deferred with documentation.	35 of 69	51%	85%
	Initial nursing care plan initiated.	68 of 68	100%	100%
	Item's triggered to integrated problem needs	41 of 67	61%	85%
	All sheets authenticated by assessing RN	66 of 69	96%	100%

Findings: All 67 charts had a nursing assessment initiated, however three were incomplete. 24 charts had sections on the assessment that the client did not participate in due to their condition upon admission. These sections were not identified as deferred with supporting documentation, within 24 hours due to client inability. The indicator for RN signing all sheets increased for 91% to 96%, however remains slightly below threshold.

Problem: While the sections on the assessment were deferred, this was not reflected in the admission note in 49% of the audited charts. Three charts universal nursing assessment were not complete in 24 hours due to client inability. All indicators are below threshold with the exception of initiating care plan. During this period, changes in nursing leadership negatively impacted training and monitoring, resulting in performance decline

Status: All sections completed or deferred with documentation decreased from 63% to 51%. Overall compliance has decreased from 92 % to 81% since last quarter. The universal assessment compliance has decreased from 99 % to 96% this quarter. Initiation of a nursing care plan remains the same at 100%. Items triggered to integrated problem needs decreased from 81% to 61%. All sheets authenticated by an RN increased from 91% to 96%. The problems are a combination of performance and process.

Actions: The Nurse Educator will reinforce the need to document all deferred sections of the assessment in the admission note. Nursing Leadership group will meet to explore more effective methods of achieving a better understanding of documentation requirements. Documentation will be reviewed, reassessed for usefulness and new methods of documentation will be developed by the end of June if deemed necessary.

Nursing

Aspect: Nursing Documentation

Overall Compliance 79%

Aspect	Indicator	Findings	Compliance	Threshold Percentile
Documentation	1. NAP notes at a minimum			
	a. Identifies STG goal/objective.	89 of 109	81%	90%
	b. Once per shift either MHW/RN	81 of 109	74%	95%
	c. Minimally Q24 hours RN.	99 of 109	91%	95%
	d. MHW notes countersigned by RN	101 of 106	95%	90%
	2. Active Treatment			
	a. Identifies Intervention	90 of 107	85%	90%
	b. Describes intervention.	30 of 70	28%	90%
	c. Assessment Completed.	102 of 108	94%	90%
	d. Plan	94 of 108	87%	90%

Findings: Two indicators, added this quarter, included “Once per shift MHW or RN” and “Minimally Q24 hours RN.” This data suggests that, RN documentation occurs per RPC standard, 91% of the time. Overall MHW/RN documentation of 74% compliance is under threshold of 95%. The 20 progress notes that were audited as not identifying a short term goal

listed on the treatment plan.

Problems: The identified short term goal is not consistent with the treatment plan short term goal on the NAP note in 19% of the cases. Some short term goals were not stated in the current treatment plan. A common short term goal stated on the NAP note was “Safety”. The writers did not reference the treatment plan prior to preparing the notes. Describing an intervention is at 28%. The narrative was observed to be written in observational terms not active treatment language.

Status: Overall compliance with documentation decreased from 84% to 78%.

Actions: The Nurse Educator will perform 20 chart audits to better identify specific needs of staff regarding documentation. The Nurse Educator will continue to reeducate staff on each unit to improve the quality of documentation. There will be individual counseling as appropriate. Information gathered from the routine chart reviews will trigger a specific staff “competency assessment,” which in turn will be used to develop specific staff skills training.

Program Service Directors

Aspect: Comprehensive Service Plans

Overall compliance: 93 %

Indicators	Findings	Compliance	Threshold Percentile
1. Initial treatment documented within 24 hours.	US 7/7 8 n/a) LS 15/15 UK 15/15 LK 15/15 Total 52/52	100% 100% 100% 100% 100%	100%
2. Preliminary Continuity of Care meeting completed by end of 3 rd day.	US 4/4 (11 n/a) LS 13/13 UK 15/15 LK 15/15 Total 47/47	100% 100% 100% 100% 100%	95%
3a Client Participation in Preliminary Continuity of Care meeting.	US 3/4 (11 n/a) LS 13/13 UK 15/15 LK 14/15 Total 45/47	75% 100% 100% 93% 96%	80%
3b. CCM Participation in Preliminary Continuity of Care meeting.	US 4/4 (11 n/a) LS 13/13 UK 15/15 LK 15/15 Total 47/47	100% 100% 100% 100% 100%	80%

3c. Client's Family Member Participation in Preliminary Continuity of Care meeting.	US 0/4 (11 n/a) LS 13/13 UK 15/15 LK 14/15 Total 42/47	0% 100% 100% 93% 89%	80%
3d. Community Provider Participation in Preliminary Continuity of Care meeting.	US 0/4 (11 n/a) LS 3/13 UK 7/15 LK 12/15 Total 22/47	0% 23% 47% 80% 47%	80%
4. Presenting Problem in behavioral terms.	US 15/15 LS 11/13 UK 14/15 LK 15/15 Total 55/58	100% 85% 93% 100% 95%	85%
5. Strengths and preferences are identified.	US 15/15 LS 11/13 UK 15/15 LK 15/15 Total 56/58	100% 85% 100% 100% 97%	85%
6. Identifies all of client's long term goals. (Needs further clarification before next quarter)	US 15/15 LS 11/13 UK 14/15 LK 3/5 Total 43/48	100% 85% 93% 60% 90%	85%
7. Comprehensive Plan complete by the 7 th day.	US 15/15 LS 11/13 UK 15/15 LK 15/15 Total 56/58	100% 85% 100% 100% 97%	100%
8. Observable behavioral objectives are written.	US 15/15 LS 11/13 UK 15/15 LK 15/15 Total 56/58	100% 85% 100% 100% 97%	85%

9. Interventions are identified.	US 15/15 LS 11/13 UK 14/15 LK 15/15 Total 55/58	100% 85% 93% 100% 95%	85%
10a. Integrated Needs/Assessment Prioritized by scale at bottom of sheet.	US 15/15 LS 11/13 UK 15/15 LK 15/15 Total 56/58	100% 85% 100% 100% 97%	85%
10b. Integrated Needs/Assessment Contains all needs/ issues/problems.	US 14/15 LS 11/13 UK 15/15 LK 15/15 Total 55/58	93% 85% 100% 100% 95%	85%
11. Active medical issues addressed via Medical/ Nursing care plans.	US 7/7 (8 n/a) LS 11/13 UK 15/15 LK 14/15 Total 47/50	100% 85% 100% 93% 94%	85%

Findings: In comparison to last quarter there was significant improvement in all indicators monitored except for 3d regarding community Provider Participation in Preliminary Continuity of Care meeting and indicator 7 Comprehensive Service Plan complete by the 7th day, only on Lower Saco.

Problems: Upper Saco has an extended length of stay population, this indicator is not applicable to their population; Lower Saco forensic population has not gotten involvement from the jails during initial planning meetings. UK is also below 80% threshold on 3d- Community Provider Participation at the preliminary continuity of care meeting. Timeliness of plan was a problem on Lower Saco however this unit now has a Nurse IV and anticipate an improvement in the next quarter.

Action: Regarding 3d, Community Provider Participation in Preliminary Continuity of Care meeting, Upper Saco should mark all 3d not applicable. Lower Saco staff will develop strategies of gaining community providers attending meeting. Deputy Superintendent of Program Services shall guide the implementation of definable

strategies prior to end of next quarter. Lower Saco, PSD will proactively send letters to the jail administrators on a monthly basis to assist in engaging the appropriate staff to come to meetings.

Program Service Directors

ASPECT: Service Plan Reviews-Documentation

Overall Compliance 94%

Indicators	Findings	Compliance	Threshold Percentile
1. Completed no later than 14 days for the first 6 months and monthly thereafter.	US 15/15 LS 13/13 UK 14/15 LK 12/13 Total 54/56	100% 100% 93% 92% 96%	85%
2. Completed within 48 hours of a restrictive treatment.	US 10/10 (5 na) LS 13/13 UK LK 6/6 Total 29/29	100% 100% ? 100% 100%	85%
3a. Review form documents client participated in the review	US 15/15 LS 13/13 UK 15/15 LK 7/12 (3 na) Total 50/55	100% 100% 100% 58% 91%	85%

3b. Review form documents psychiatrist participated in the review	US 15/15 LS 13/13 UK 15/15 LK 9/12 (3 na) Total 52/55	100% 100% 100% 75% 95%	85%
3c. Review form documents CCM participated in the review	US 15/15 LS 13/13 UK 15/15 LK 12/12 (3 na) Total 55/55	100% 100% 100% 100% 100%	85%
3d. Review form documents nurse participated in the review	US 15/15 LS 13/13 UK 15/15 LK 12/12 (3 na) Total 55/55	100% 100% 100% 100% 100%	85%
4. Review form indicates plan as having met identified goals.	US 12/15 LS 11/13 UK 4/15 LK 12/12 Total 39/55	80% 85% 27% 100% 71%	85%
5. Review form states whether client continues to meet admission criteria.	US 15/15 LS 13/13 UK 15/15 LK 12/12 Total 55/55	100% 100% 100% 100% 100%	85%

Findings: 5 charts per month was the sample size. Reviewers were the Program Services Directors. All indicators were met except for Number 4, Review form indicates plan as having met identified goals, which is at 71%.

Problems: The tool needs to be adjusted to reflect change of plan within 72 hours. Lower Kennebec was below the threshold of psychiatrist documenting attendance, and client attending treatment meeting. Upper Kennebec was at 27% regarding plan identifying goals

Actions: Collection tools and methods will be revised to assure information collected is valid. Deputy Superintendent and Performance Improvement Direct shall (1) collect a focused sample on all indicators, (2) review reliability of collection methods, and (3) provide education or counseling as necessary before May 20, 2006.

Program Service Director

Aspect: Integrated Summary Note

Overall Compliance 84%

Indicators	Findings	Compliance	Threshold Percentile
1. Documented in the chart on the day of the Comprehensive Service Plan Meeting.	US 4/4 (11 na) LS 12/13 UK 14/14 LK 15/15 Total 45/46	100% 92% 100% 100% 98%	85%
2. Identifies Client Preferences.	US 4/4 (11 na)) LS 6/13 UK 14/14 LK 11/15 Total 35/46	100% 46% 100% 73% 76%	85%
3. Identifies general needs of client -- identified on completed assessment.	US 4/4 (11 na) LS 12/13 UK 14/14 LK 15/15 Total 45/46	100% 92% 100% 100% 98%	85%
4. States whether further assessments will be needed or not.	US 4/4 (11 na) LS 10/13 UK 8/14 LK 10/15 Total 32/46	100% 77% 57% 67% 70%	85%

5. Identifies the general goals of services.	US 4/4 (11 na) LS 11/13 UK 14/14 LK 15/15 Total 44/46	100% 84% 100% 100% 96%	85%
6. Documents the client or guardian participation in the treatment planning process.	US 4/4 (11 na) LS 12/13 UK 14/14 LK 13/15 Total 43/46	100% 92% 100% 87% 93%	85%

Findings: # 2, Identifies client Preferences, on US and UK improved to 100%; LS was at 46%; LK dropped below threshold to 73%. # 4, States whether further assessments will be needed or not, continues to be an issue for all units except US. Total declined from 79% to 70% which is below the threshold of 85%.

Problems: Identification of client preferences and need for further assessment are not clearly documented.

Actions: Deputy Superintendent of clinical services and the Director of Process Improvement will review indicators and explore processes for capturing required data fields by 5-20-06.

Program Service Directors

Aspect: Progress Note

Overall Compliance: 90%

Indicators	Findings	Compliance	Threshold Percentile
1. Review note indicates changes made in the plan to implement further progress.	US 15/15 LS 11/13 UK 12/15 LK 7/12 Total 45/55	100% 85% 80% 58% 82%	85%

2. Level of client participation in active treatment is documented.	US 15/15	100%	85%
	LS 13/13	100%	
	UK 14/15	93%	
	LK 10/12	83%	
	Total 52/55	95%	

Findings: UK and LK continue to be below threshold on number one, Review note indicates changes made in the plan to implement further progress.

Problems: Documentation is not reflecting changes made in plan to further client progress.

Action: A tool was developed to prompt nursing staff to document to reflect changes; Documentation tool will be implemented by 5-10-06.

Peer Specialists

Aspect: **Integration of into client care**

Overall Compliance: 83%

Indicators	Compliance	Findings	Threshold Percentile
1. Attendance at Comprehensive Treatment Team meetings.	378 of 486	78%	80%
2. Grievances responded to on time.	94 of 99	95%	100%
3. Attendance at Service Integration meetings.	69 of 69	100%	100%

Finding: (1) Percentage of Comprehensive Treatment Team meetings attended, improved this quarter. (2) There is no change from last quarter in the percentage of late grievances. Five grievances not responded to within identified timeframe, all were responded to within 8 days. (3) All Service Integration Meetings were attended this quarter. Peer Specialists have been notified regularly of meetings this quarter.

Actions: Peer Specialists will continue to track Comprehensive Treatment Team Meeting attendance and reasons for not attending.

- The grievances response time will continue to be monitored.
- Peer Specialists will make additional efforts to adjust their schedules to be available for meetings.

- Peer Support Coordinator is being more active on the units in order to cover for outages and conflicts that interfere with treatment team attendance.

Rehabilitation

Aspect: **Client Attendance at the Harbor Mall**

Overall Compliance: **67%**

Indicators	Findings	Compliance	Threshold
Attendance by clients scheduled to attend mall groups on a daily basis	2899 of 4381	66%	70%
Attendance at morning programming	1648 of 2435	68%	70%
Attendance at afternoon programming	1251 of 1946	64%	70%

Finding:

The sample is based on a 13-week session of the Harbor Mall from 1/1/06 to 3/31/06. For the 13-week period, the morning programming had 1648 client interactions out of a possible 2435 for a 68% total, down 4% from last report. The afternoon programming had 1251 client interactions out of 1946 for a 64% total, up 3 % from the last report. This means that for the 62 days the mall was in session we had a compliance rate of 67%. As a result of the action steps taken last quarter, there was an increase in the afternoon programming. The morning program did have a decrease and additional steps will be added for next quarter to further explore and evaluate the reason for this. We have an average daily attendance in the morning of 27 clients and 20 for the afternoon.

Problem:

Riverview has been continuously showing an improvement and had reached threshold percentile for morning program last quarter. This quarter the afternoon program continued to show an improvement, however the morning program had a 4% decrease.

Status:

- Rehab staff have completed approximately 80% of the Psychiatric Rehabilitation Training and has developed a new assessment tool and will look to begin using this next quarter.
- A client survey was completed to gather information and suggestions in relation to programming on the Mall. The suggestions are being implemented with the

- new schedule starting on April 3rd, 2006.
- Rehab. staff have all received engagement training.
- Engagement plans continue to actively evolve with those clients that have been refusing to participate in any groups. The afternoon program continues to improve going from what once was a 55% compliance rate to what is a 64% rate to date.

Actions:

- Rehab. Service staff will complete training on Psychiatric Rehabilitation by the end of the FY and will implement new assessment tool and care plan.
- The Mall will begin its Spring Session programming to include the groups that were suggested by clients in the survey as well as from the Client Forum.
- Rehabilitation Services Director will monitor the attendance and will send the client's schedule to each Recreation Therapist for review and possible change to an engagement intervention.

Vocational Services Program

Aspect: Job Coach Attendance at Comprehensive Service Plan Meetings.

Overall Compliance: 89%

Indicator	Findings	Compliance	Threshold Percentile
The Job Coach will attend assigned clients' treatment plan meetings.	57 of 64	89%	80%

Findings: Improvement from 81% to 89% this quarter. Increase was attributed to improved communication and an addition of a job coach in January. Meetings that were missed were due to mandatory training or call outs.

Problem: None noted.

Status: Compliance rate has been met or exceeded for the recent quarters for treatment plan meeting; this will continue to be monitored.

Actions: Focus will change to look at those clients who are interested in working in the community. Currently have a high number of clients working at jobs here in the facility, but who have potential for community employment.

Health Information Services

Aspect: Documentation and Timeliness

Overall Compliance: 97%

INDICATORS	COMPLIANCE	THRESHOLD PERCENTILE
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1. Records will be completed within JCAHO standards, state requirements and Medical Staff bylaws timeframes.	77% -There were 23 discharges in January. Of those, 20 were completed by 30 days. 93%-There were 28 discharges in February. Of those, 25 were completed within 30 days. 84 %-There were 19 discharges in March. 16 were completed within 30 days.	All records will be completed within 30 days of discharge. The completion rate will remain at or above 80%.
2. Discharge summaries will be completed within 15 days of discharge.	100 % - 23 out of 23 were completed within 15 days in January. 96% - 27 out of 28 were completed within 15 days in February. 100% - 19 out of 19 were completed within 15 days in March.	The completion rate will remain at 100%.
3. Forms used in the medical record will be reviewed by the Medical Record Committee.	100%- 0 forms were approved/revised in January (see minutes). 100 %- 0 forms were approved/revised in February (see minutes). 100 %- 0 forms were approved/revised in March (see minutes).	100%
4. Medical transcription will be timely & accurate.	100 %-no errors/issues in January. 100%-no errors/issues in February. 100 %-no errors/issues in March.	90%

Findings: The indicators are based on the review of all discharged records. There was 85 % compliance rate with record completion within 30 days. There was 99% compliance rate with discharge summaries. Weekly “charts needing attention” lists are distributed to all medical staff, including the Clinical Director.

Problem: Record completion has decreased from 84% last quarter to 78% this quarter.

Status: 78% compliance rate with record completion.

Actions: All medical staff (including the Medical Director) receives weekly notification regarding “charts needing attention”. Medical Staff are notified via telephone call and or e-mail regarding any discharge summaries that need to be completed prior to deficiency.

The above indicators will continue to be monitored with staff having patterns of deficiency being counseled.

Health Information Services

Aspect: Confidentiality

Overall Compliance: 100%

INDICATORS	COMPLIANCE	THRESHOLD PERCENTILE
1. All client information released from the Health Information department will meet all JCAHO, State, Federal & HIPAA standards.	100 %-no issues in January. 100 %-no issues in February. 100%-no issues in March.	100%
2. All new employees/contract staff will attend confidentiality/HIPAA training.	100 % -4 new employees/contract staff in January. 100% -3 new employees/contract staff in February. 100%-7 new employees/contract staff in March.	100%
3. The Director of Health Information will track the number of confidentiality/privacy issues through incident reports.	There were 0 confidentiality/Privacy-related incident reports in January. There were 0 confidentiality/privacy related-incident reports in February. There were 0 confidentiality/privacy-related incident reports in March.	Incident reports will be monitored for privacy issues. The incident rate will remain at 0%.

Findings: The indicators are based on the review of all requests for information, orientation for all new employees/contracted staff and confidentiality/privacy-related incident reports. **2421 out of 2421** (100%) requests for information (2201 police checks and 220 requests for client information) were released from the Health Information department during this quarter. 14 out of 14 (100%) new employees/contract staff attended Confidentiality/HIPAA training. All indicators remained at 100 % compliance for quarter 1-FY 2006.

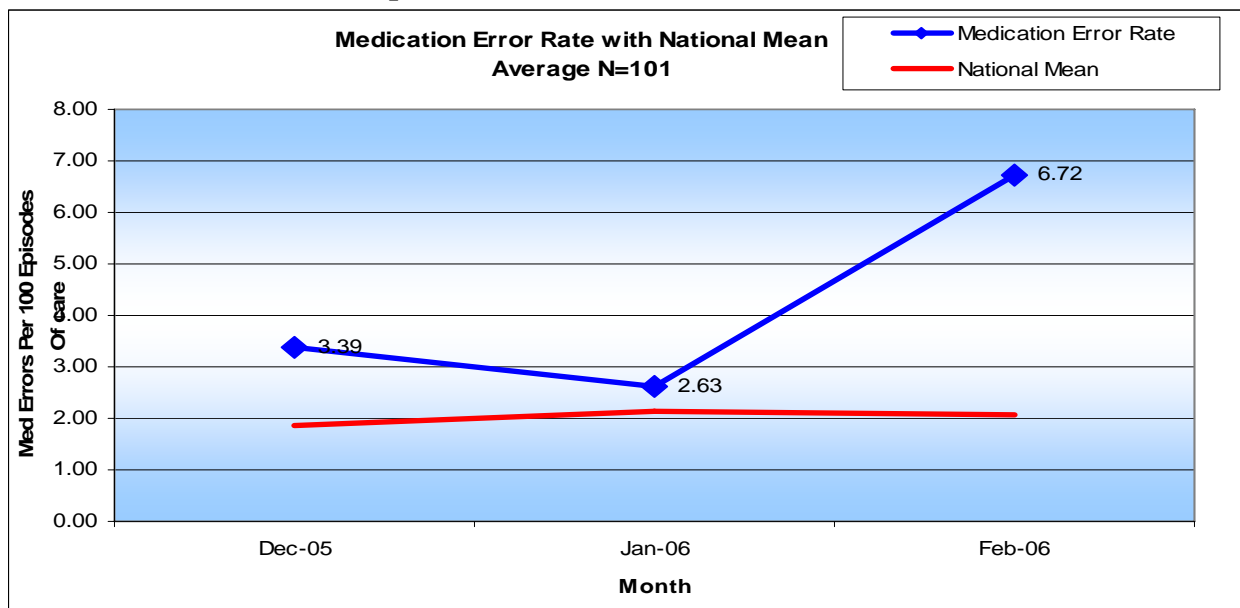
Problem: None found. Still, the introduction and compliance with current law and HIPAA regulations needs to be strictly adhered to, requiring training, education, and policy development at all levels.

Status: No issues during quarter 3. Continue to monitor.

Actions: The above indicators will continue to be monitored.

HOSPITAL PERFORMANCE MEASURES

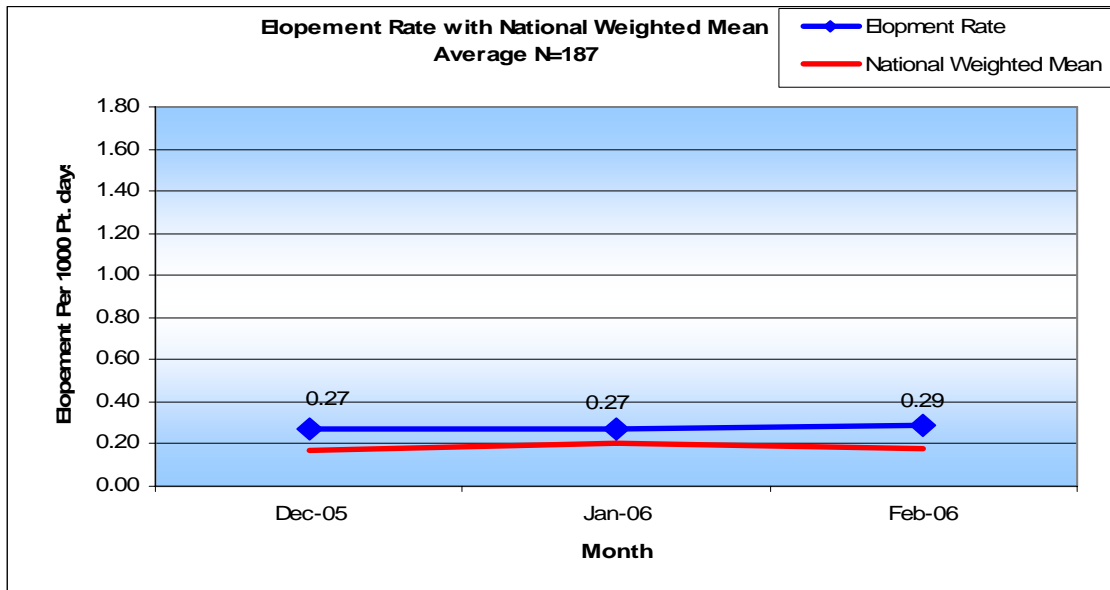
Medication Error Rate-Comparisons with National Data



After a consistent decline the spike in Feb is concerning and the quarter was above the national mean. Since these med errors seem to be concentrated on new hires, the

Director of Nursing has reviewed the orientation of nurses to the medication management system and has made changes in the process. Medication variances are monitored 24/7 and self reporting is an expectation; Pharmacy also notifies risk management, and nursing of concerns from any trends they may be seeing.

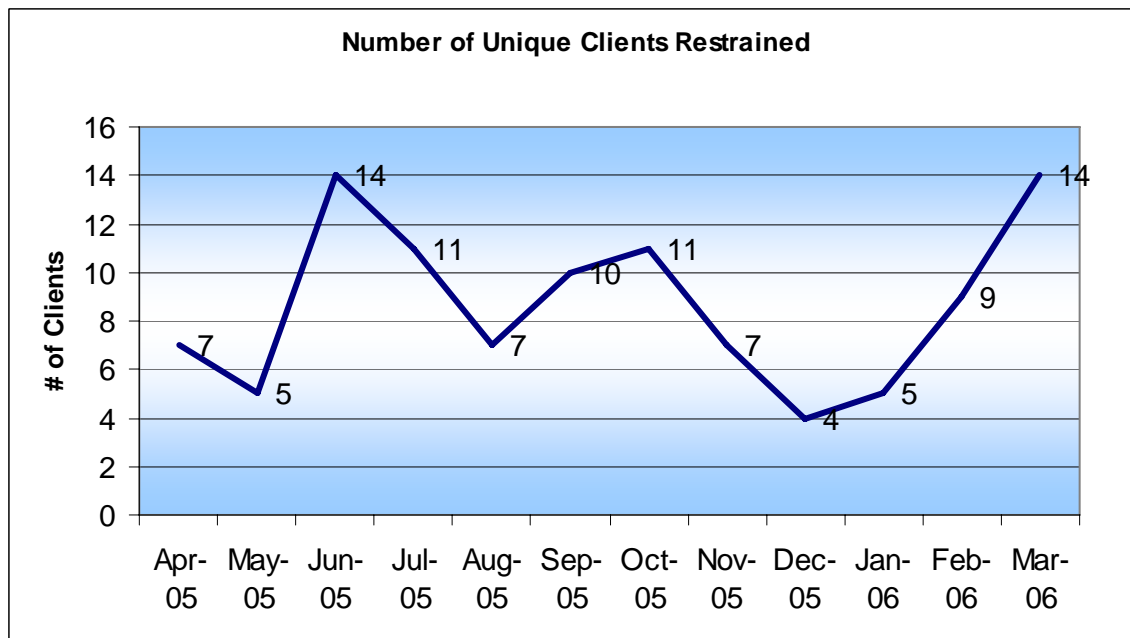
Elopement Rate-Comparisons with the National Data

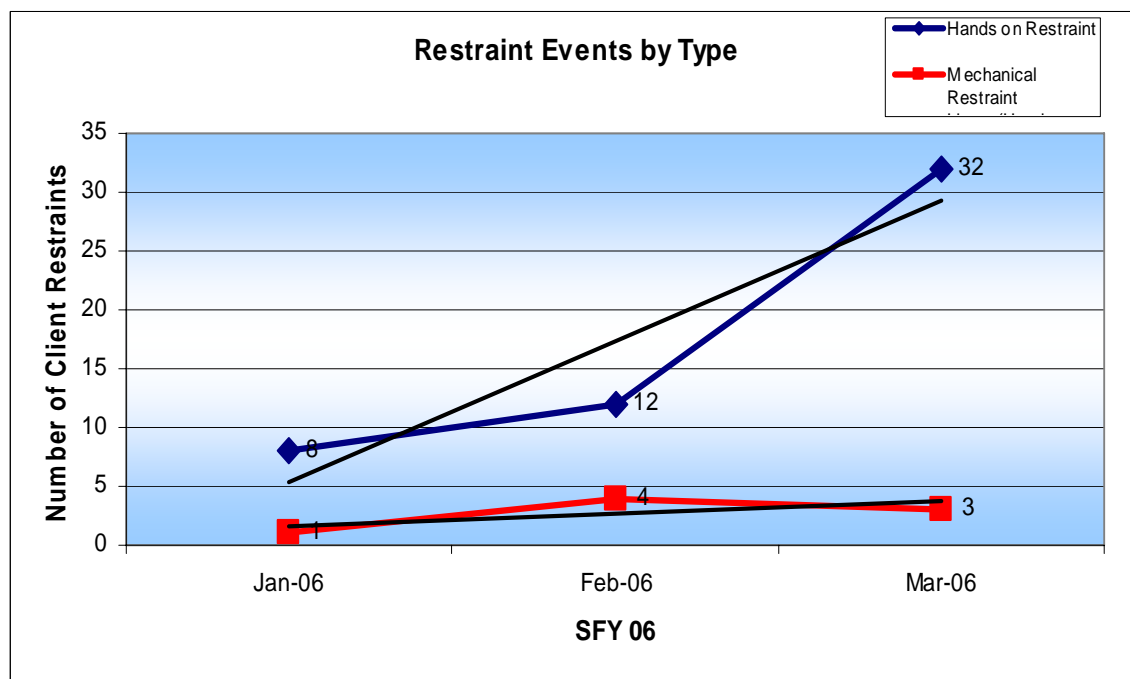
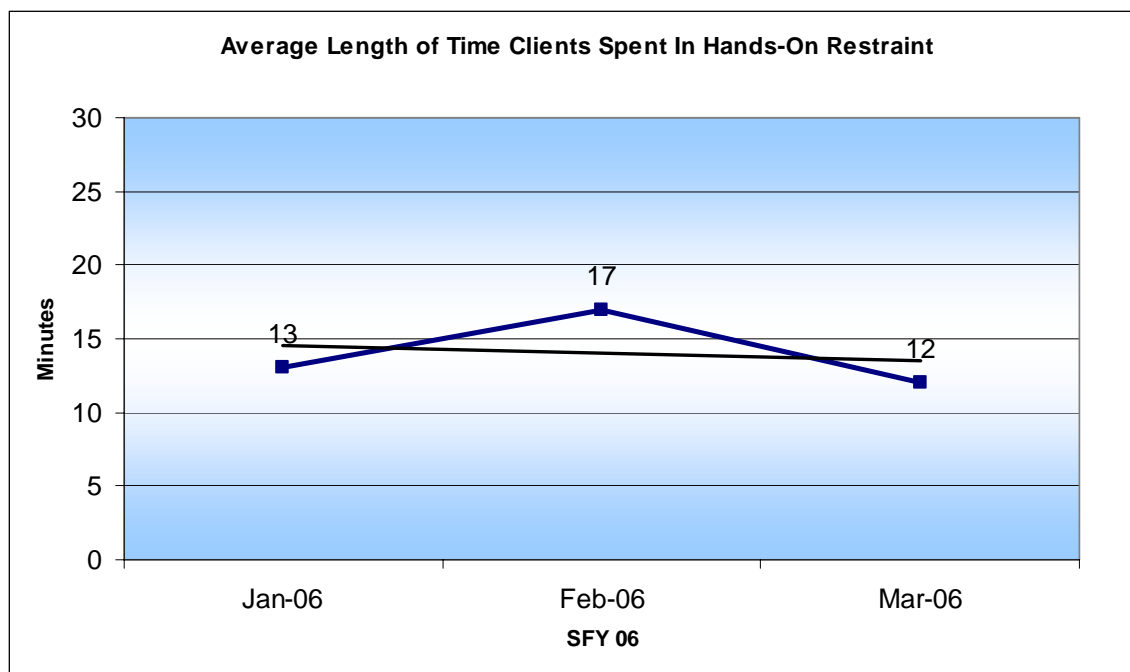


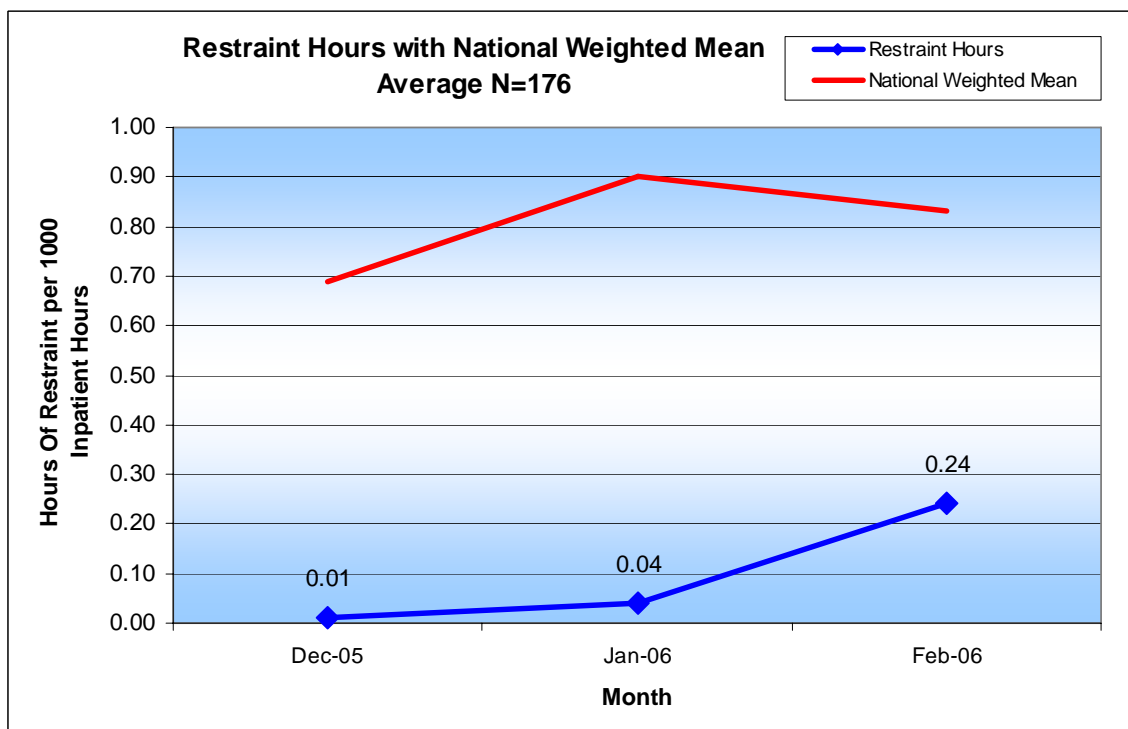
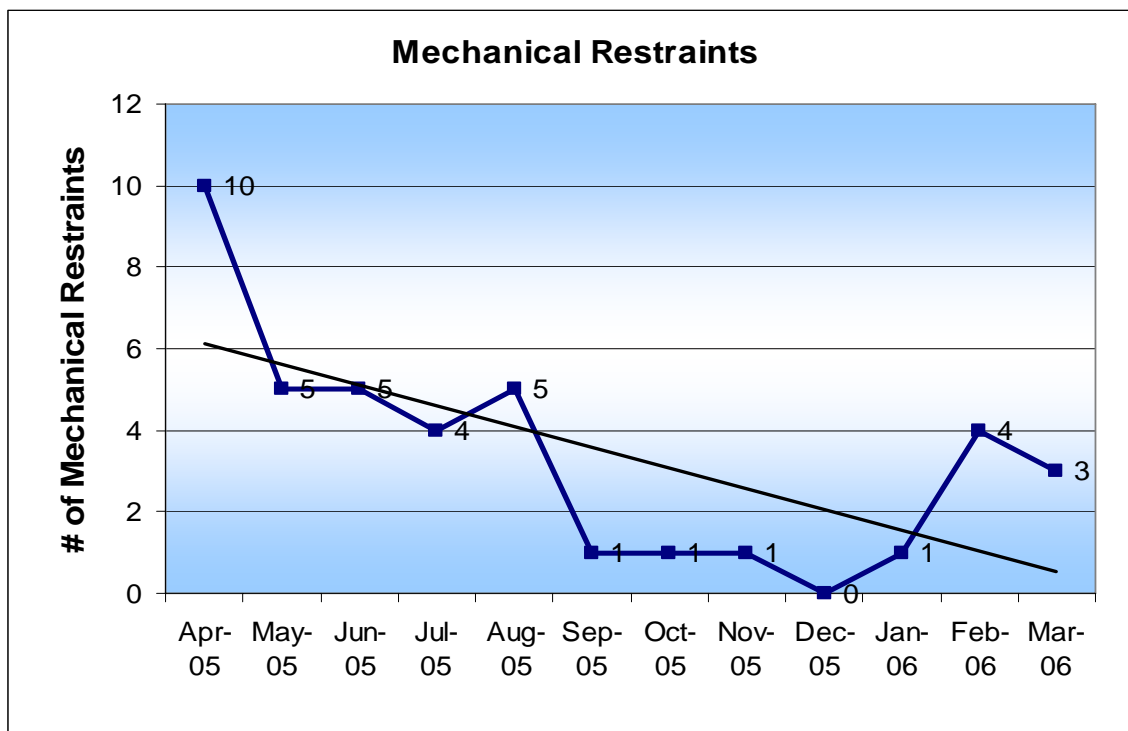
Riverview Elopement rates continue to be well in-line with the National averages

Restraints

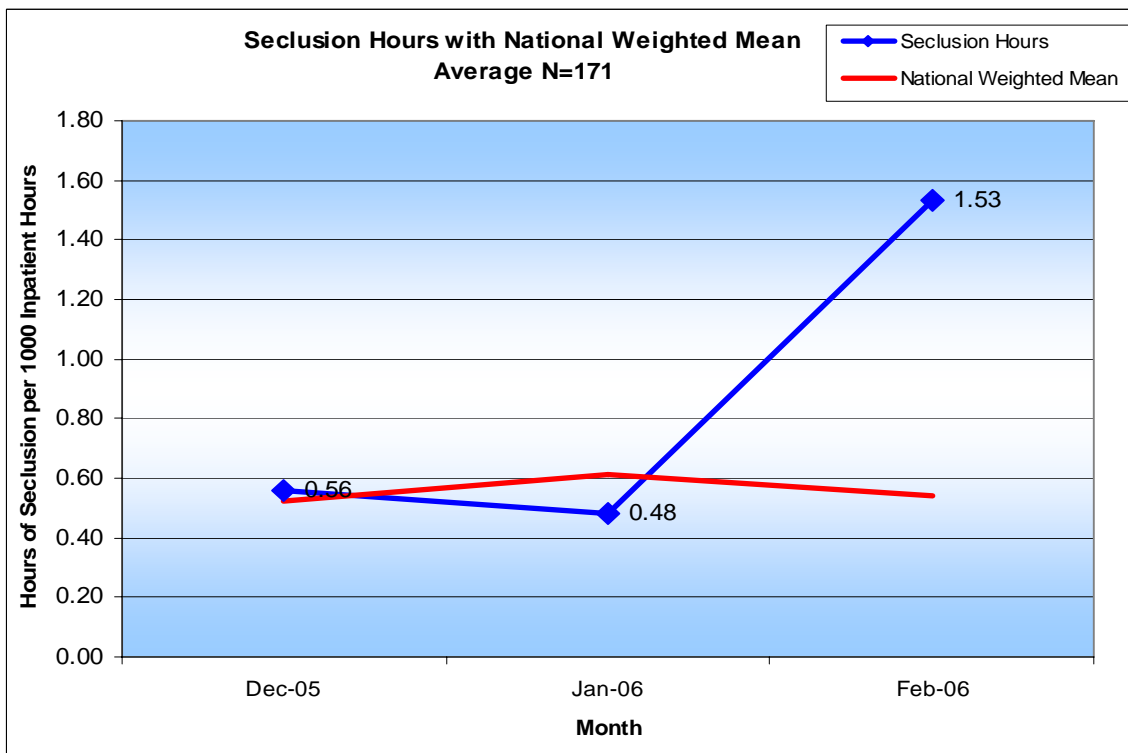
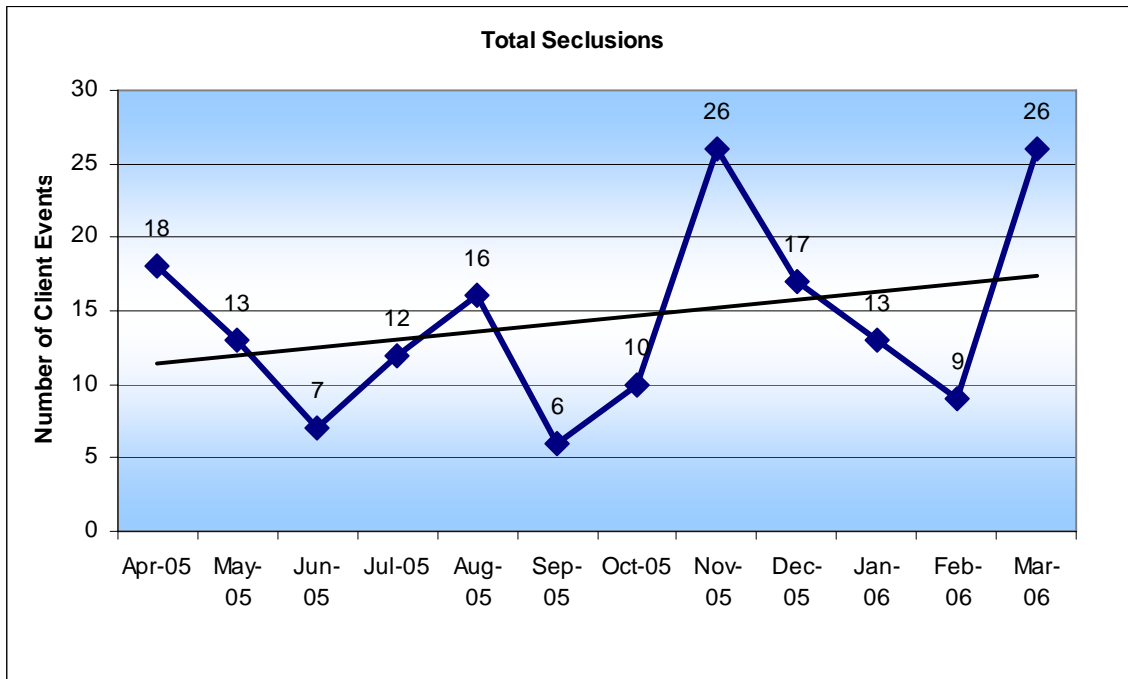
After eleven months of general decreases in restraint events, March 06 spiked in use.





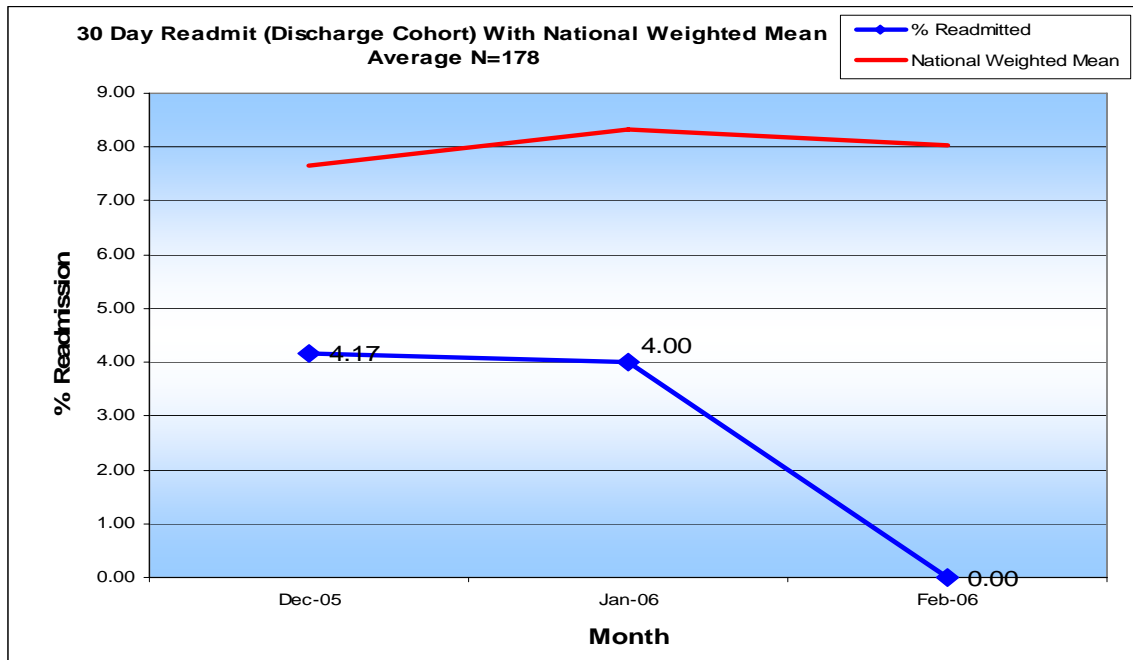


Seclusions



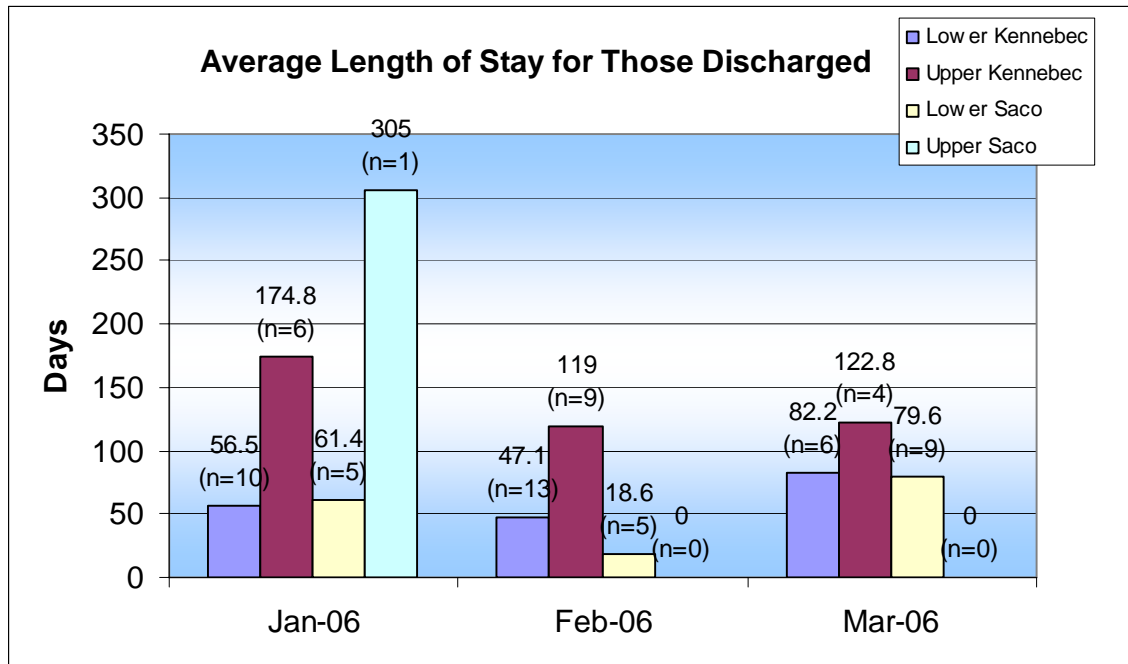
Along with restraints, the hospital has been working to decrease client seclusion events; it is a national initiative. Such events are triggers to the treatment team to review a client's plan of care within 72 hours to help address the client's treatment needs. Administrative Segregation was implemented during this quarter, in February.

Readmissions within 30 days



The graph depicts the 30 day readmission rate continually decreasing.

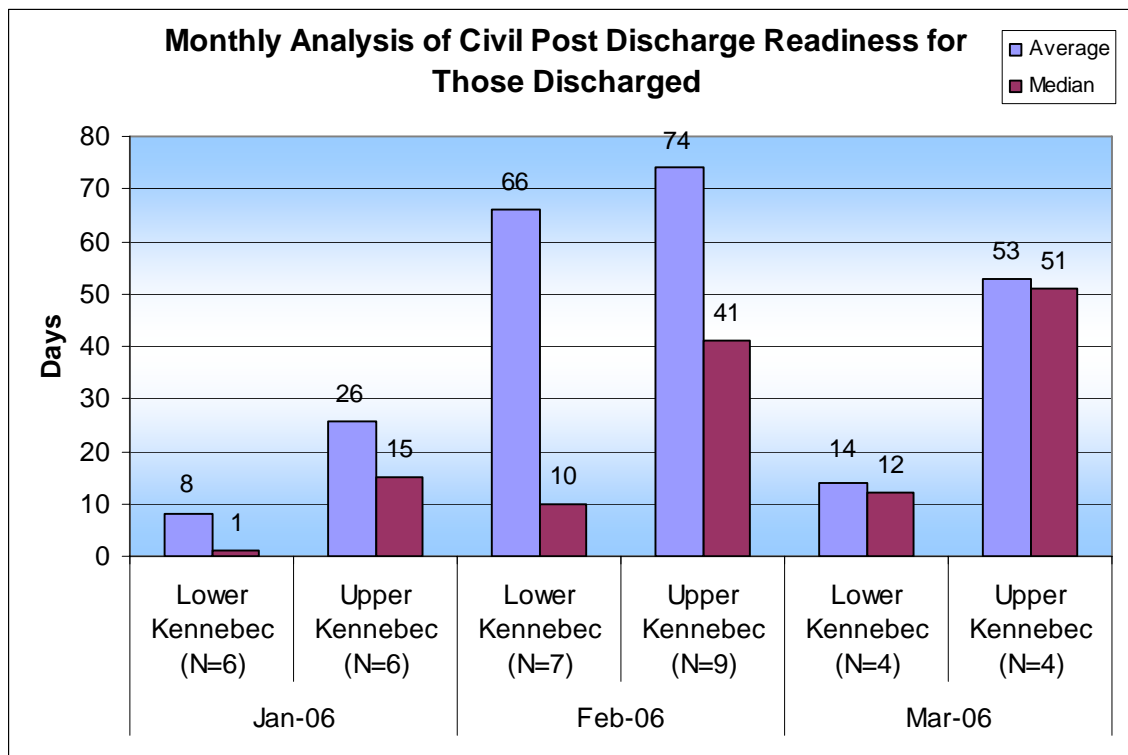
Average Length of Stay



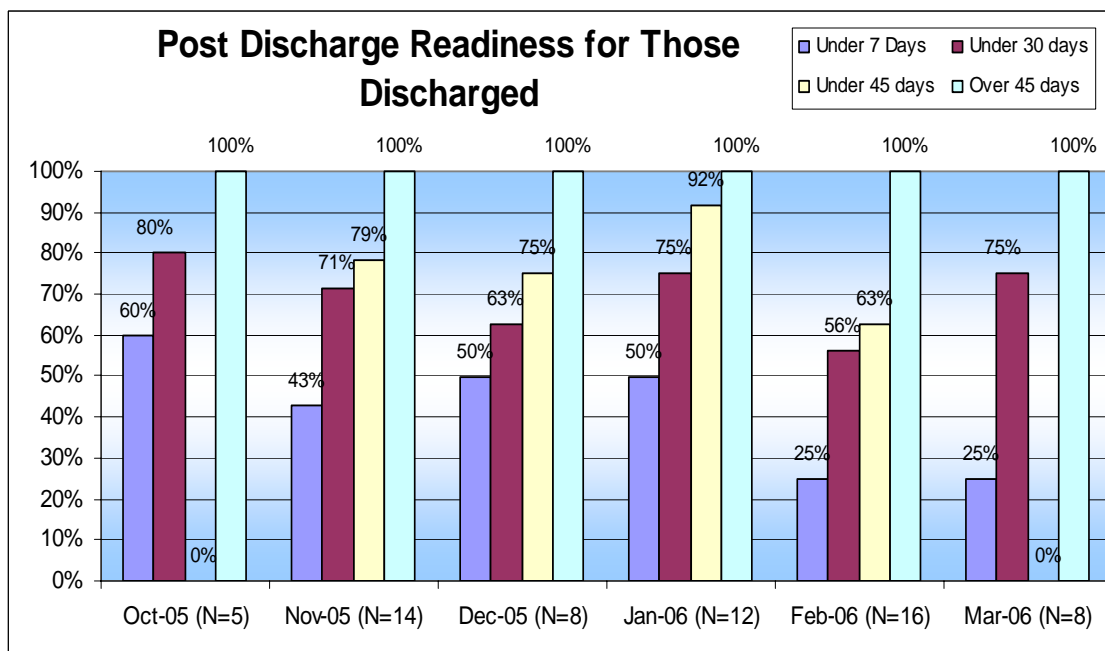
Hospital Performance Measure Discussion:

The hospital operates two distinct units for both the civil and the forensic population. The forensic units are Upper Saco and Lower Saco. Riverview's Upper Saco unit houses the long stay clients who have been adjudicated as "Not Criminally Responsible" (NCR) by the court. Given this population, there are typically very few clients discharged from that unit in any given quarter. The Lower Saco unit serves a forensic population that includes the short-term jail transfers, clients undergoing Stage III evaluations regarding competency to stand trial, and clients determined to be "Incompetent to Stand Trial" (IST). Upper Kennebec serves acute and non-acute longer-term civil clients. Lower Kennebec is the admissions unit for acute civil clients.

Average Post Discharge Readiness Days for Civil Clients Discharged

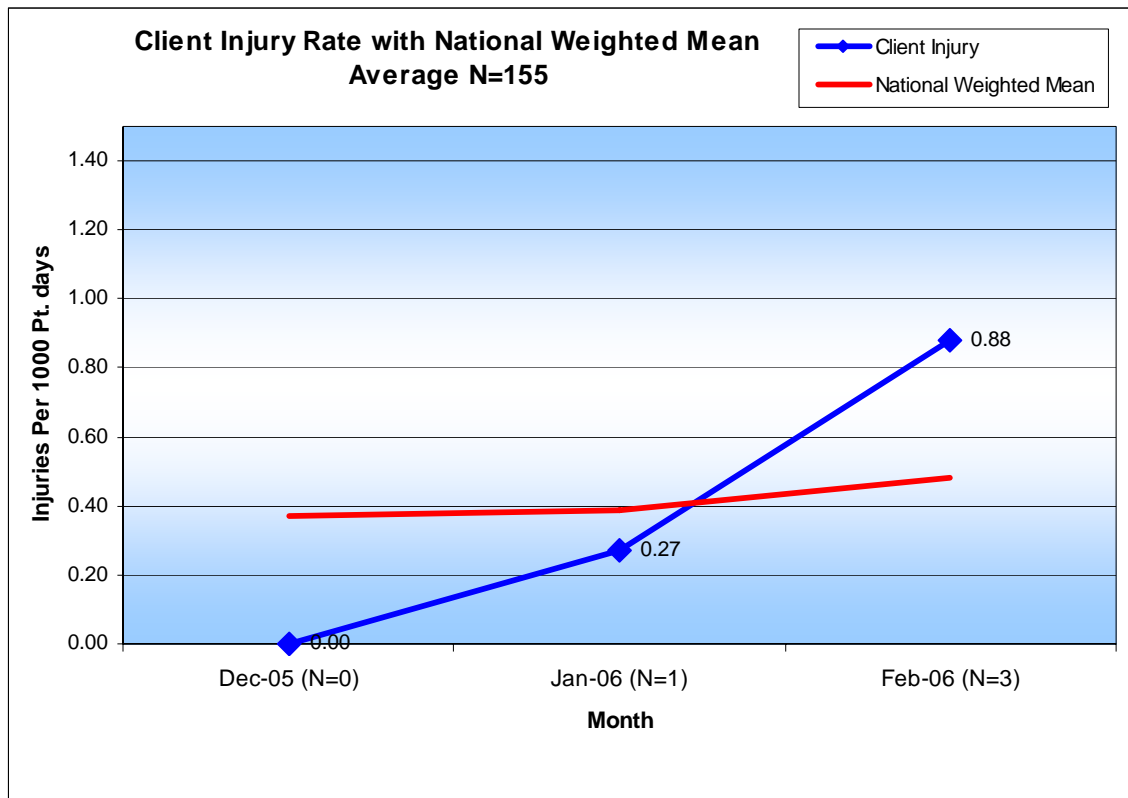


The hospital also collects data on the time a client spends in the hospital after they have been determined ready for discharge, before they are actually discharged.



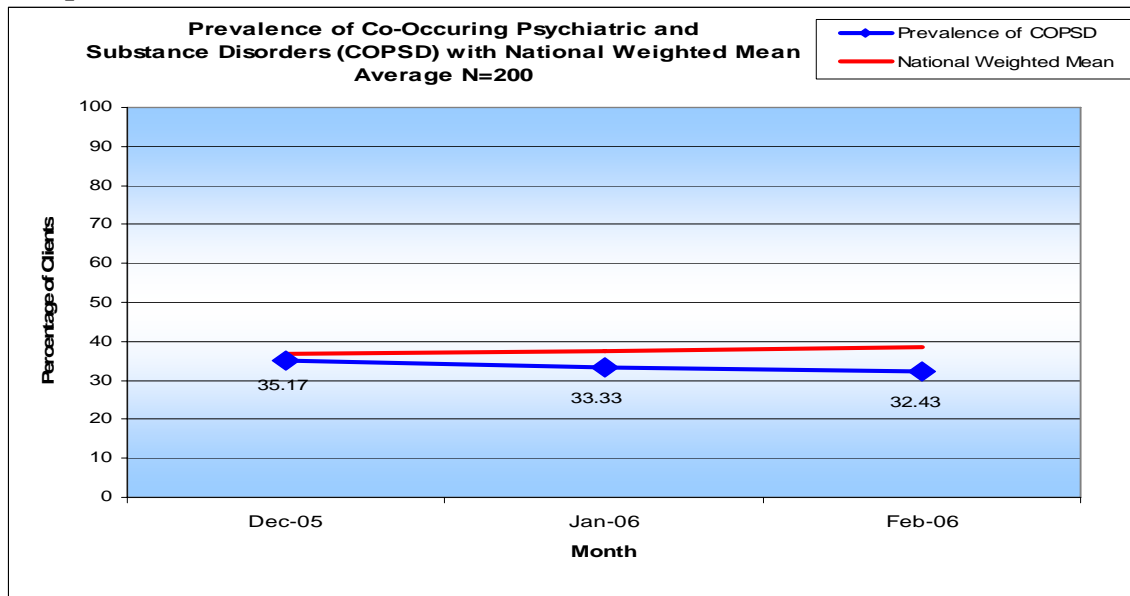
Over the past 6 months, RPC on average discharged 75% of all clients, within 45 days of a determination they are ready for discharge.

Client Injury Rate compared with National Data.



Client injuries increased in February as increases in client episodes of self-harm occurred. This quarter the highest category of injuries that caused injury greater than first aid were self harming injuries.

Prevalence of Co-Occurring psychiatric and Substance Abuse Disorders Comparisons with National Data (COPSD)



Hospital Performance Measure Discussion

Currently, Riverview percentage of clients presenting with co-occurring psychiatric and mental health disorders is similar to that being experienced by other hospitals Nationally. RPC clients are currently offered a limited variety of group treatment however; RPC has recently awarded an RFP for an intensive and extensive co-occurring disorder program for all of RPC, with another psychiatric inpatient hospital. With this increased attention, RPC expects the clients identified as needing, benefiting and participating in treatment programs will increase significantly